CONTENTS

For November, 1935

Just in Passing—

OUR cover this month shows a southeast view of the Pennsylvania Hospital, Philadelphia, to which a charter was issued in the year 1751. It is of interest to the hospital historian to read of the friendly controversy that has existed for many years as to whether Philadelphia General or Pennsylvania Hospital was the first hospital in the United States. There can be little doubt that the first almshouse infirmary, from which has grown the Philadelphia General, was in existence almost two decades prior to the construction of Pennsylvania Hospital. There can be likewise no doubt of the fact that the first incorporated hospital in the United States was the Pennsylvania Hospital. Benjamin Franklin in his autobiography gives an interesting account of its origin.

THE first article in the promised series on the administration of hospitals for mental and nervous diseases will be found on page 41 of this issue. Logically enough Doctor Parsons deals with the matter of building. A splendid group of articles will succeed this one in alternate months. The next one, to appear in the January issue, will discuss the clinical facilities of the modern mental hospital as seen by Dr. G. H. Stevenson. Following this will come "Continued Training in the Professional and Nonprofessional Personnel" by Dr. Franklin G. Ebaugh, "Dietary and Food Service" by Dr. William A. Bryan and "The Value of a Dairy Farm to the Hospital for Mental Diseases" by Dr. Ira A. Darling. Others who have promised to contribute to

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CONTENTS

the series are Dr. Ellen Potter on public relations, Dr. C. H. Creed on farming, Dr. C. F. Williams on housekeeping, Dr. C. C. Burlingame on personnel, Dr. H. I. Klopp on purchasing methods, Dr. Winfred Overholser on records and Dr. M. Raynor on medical economics. The series will continue over a two-year period.

DOUBLE standards for marriage have had hard going. In the hospital field, however, we still seem to think a double standard justified. We act as though we believed it were proper for the ward patient in a county or other government hospital to be satisfied with a lower standard of care than the ward patient in a voluntary hospital — and expect him to be grateful into the bargain. How about it? Is there a double standard? If there is in practice, can we justify it? Next month the Editor will put this question squarely before the field.

DR. MAC LEAN says that the superintendent is a combination innkeeper, sergeant major and diplomat (p. 69). He discusses, however, only his diplomatic functions. Next month Dr. A. J. Hockett will tell of his work as an innkeeper. Hospitals can, and some hospitals have, learned much from hotels. You will find Doctor Hockett's discussion full of practical suggestions.

CHRISTMAS is just around the corner and the wise superintendent will begin to lay his plans shortly. The dietetic department next month will feature a special Christmas article that will be helpful.

IF it is time to think of Christmas it is also time to think of the New Year and the hospital's annual report. Dr. Hugh Cabot says that "statistics are like fish; they don't keep long." That is a good precept to remember in connection with the annual report. Why not aim to have it out during January while its contents will still be fresh and interesting? Next month, Doctor Mooney of Buffalo will tell what he believes should go into an annual report. No spinster expert on children, he has

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produced an annual report that is, in the language of the street, a "knock-out."

AN out-of-date and inefficient clinical laboratory is neither a credit to an institution nor a stimulus to good professional work. Yet modernizing the laboratory need not be unduly expensive if one possesses ingenuity and determination. Dr. Marcus D. Kogel will describe next month how the laboratory in one of New York City's municipal hospitals was modernized at limited expense. What was done under his limitations could be done under almost any other circumstances.

FLASHES FROM THIS ISSUE:

"When possessed of all of the facts in a given case the news writer can do justice to all concerned, whereas evasion or concealment of fact may react to the hurt of the institution." *Page 38.*

"Tray appeal is not confined to cleanliness, essential as such as an attribute unquestionably is, nor does it rest with any precise arrangement of silverware or dishes." *Page 98.*

"It seems conclusive that one type of standard training for all nurses can hardly be applied to the various needs of our modern social life." *Page 52.*

"The responsibility for establishing proper relations with the public and with other social and health agencies devolves upon the administrator." *Page 37.*

"Whenever possible in an institution it is recommended that employees buy their meals instead of having the meals represent a part of their wages" *Page 94.*

"Newspapers claim, and not without justice, that accidents to prominent persons are news and that it is in the public interest to make such news available." *Page 71.*

"In the prenatal clinic a splendid opportunity is to be found to make use of the services of the dietitian." *Page 79.*

"There is almost no limit to what the dietitian can do with paper napkins and tray covers for special occasions." *Page 98.*

"An enlightened and understanding public is the institution's best ally in times of stress and such a public will be quick to protect the hospital's interests." *Page 39.*

"The laboratory technician is a comparatively new creature." *Page 45.*

THE MODERN HOSPITAL

THE MODERN HOSPITAL PUBLISHING CO., INC.
OTHO F. BALL, M.D., *President*
919 NORTH MICHIGAN, CHICAGO, ILLINOIS

JOSEPH C. DOANE, M.D., *Editor*
ALDEN B. MILLS, *Managing Editor*
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Even Baby Likes His Nurse « «

AND who wouldn't like Joan in the tidy uniform and crisp white apron and bib which still look fresh after months of use.

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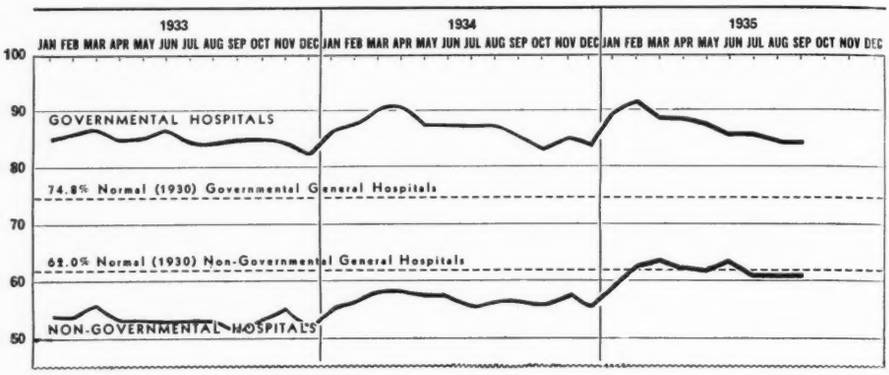
The Hospital Barometer

Voluntary hospital occupancy increased slightly in September the lead over last year which has been noticeable during all of 1935. Occupancy was at 61.3, on the basis of preliminary figures, as compared with 56.3 a year ago. The usual seasonal decline in occupancy was conspicuous by its absence. In the government general hospitals occupancy stayed also at the same figure as in August but continued to be lower than in August of 1934.



Hospital construction showed a decided spurt during the period from September 24 to October 24, inclusive. Thirty-four new projects were reported during this period which are estimated to cost $9,569,850. One of these is a $350,000 nurses' home, fifteen are new hospitals which will cost nearly $6,000,000 and eighteen are additions to existing hospitals which are being made at a total cost of $3,233,870. The average cost per project was $284,000.

"Business continues to improve," states the heading on the monthly survey of the National Industrial Conference Board. The improvement noted during the last three months continued through September and the first half of October. Electric power output rose during early October to the highest level on record. Gains were also registered during September in the steel industry, residential building, railroad shipments and distribution and trade. Preliminary reports to the board of hourly earnings in twenty-five manufacturing industries indicate no decline in wage rates since last May. Average rates per hour were 60.2 cents in September compared with 59.3 cents last May. Comparison of total pay rolls for September with other months and years is particularly difficult because of the pronounced shift this year in the seasonal movement of automobile production.

The wholesale price index of the *New York Journal of Commerce* showed little change during the month, advancing from 81.2 on September 21 to 82.1 on October 19. This is slightly higher than the level reached in May, the last month of operation under NRA codes. Grain prices advanced markedly from 92.7 on September 21 to 97.0 on October 5 but then fell off even more when war in Europe seemed less imminent. On October 19 the index was down to 90.2. General food prices were not so noticeably affected, rising from 84.8 on September 21 to 85.8 on October 19. Textiles and fuel both advanced in price during the period while building materials fell off one point. The price of drugs and fine chemicals as indicated by the index of the *Oil, Paint and Drug Reporter* advanced slightly from 188.5 on September 23 to 190.3 on October 21. This advance is at a faster rate than is ordinarily noted for this index.

OCCUPANCY FIGURES OF HOSPITALS IN VARIOUS STATES AND CITIES

Type and Place	Census Data on Reporting Hospitals[1]		1934				1935								
	Hospitals	Beds[2]	Sept.	Oct.	Nov.	Dec.	Jan.	Feb.	March	April	May	June	July	Aug.	Sept.
Nongovernmental															
New York City[3]	68	15,194	61.0	66.0	68.0	66.0	70.0	72.0	74.0	70.0	75.0	75.0*	75.0*	75.0*	75.0*
New Jersey	58	9,772	58.0	60.0	61.0	58.0	62.0	65.0	66.0	65.0	66.0	64.0	62.0	62.0*	62.0*
Washington, D. C.	9	1,782	60.7	65.4	65.3	61.8	72.0	71.8	70.5	69.8	68.7	70.6	68.2	62.0	62.0*
N. and S. Carolina	100	5,861	60.9	61.1	60.9	56.8	60.6	63.1	64.9	62.3	64.6	66.8	65.7	66.3	65.5
New Orleans	7	1,198	49.5	49.5	47.7	44.9	47.7	49.5	50.1	46.8	50.9	58.3	57.1	58.2	55.1
San Francisco	16	3,043	60.8	64.2	63.2	62.0	65.5	68.2	67.4	69.5	66.4	67.4	62.4	63.9	63.9
St. Paul	7	997	43.4	39.1	45.8	45.8	41.5	53.6	55.9	52.3	48.8	51.7	46.4	48.3	49.4
Chicago	25	6,372	55.6	56.9	57.9	54.5	57.4	57.3	61.9	58.8	55.9	54.7	54.5	53.8	53.6
Cleveland	6	1,183	56.7	57.8	57.7	56.5	61.9	62.0	62.0	63.6	65.7	63.4	63.2	63.4	65.5
Total[4]	296	45,402	56.3	57.7	58.6	56.3	59.8	62.5	63.6	62.1	62.4	63.5*	61.7*	61.4*	61.3*
Governmental															
New York City	16	11,615	88.3	89.4	91.0	92.9	96.7	100.6	103.2	104.6	105.6	100.4	103.6	93.2	91.7
New Jersey	6	2,122	80.0	83.0	81.0	78.0	86.0	86.0	84.0	85.0	84.0	77.0	79.0	79.0*	79.0*
Washington, D. C.	2	1,316	81.7	78.1	84.8	77.6	86.6	95.5	76.3	72.7	69.4	67.4	68.4	69.5	69.5*
N. and S. Carolina	13	1,256	64.0	67.0	68.3	64.7	65.4	65.7	68.5	65.8	68.6	68.1	68.7	72.3	68.0
New Orleans	2	2,227	148.0	129.3	131.6	130.5	144.9	145.4	130.4	130.8	132.8	138.8	149.0	143.1	140.9
San Francisco	3	2,255	74.4	72.7	78.1	74.2	77.4	79.1	77.1	80.3	77.3	72.3	72.0	71.3	79.5
St. Paul	1	1,050	67.3	66.8	68.5	68.8	74.4	78.7	77.8	75.8	75.2	74.5	67.3	63.4	63.5
Chicago	1	3,300	83.1	84.8	87.0	84.7	89.0	83.4	93.9	84.2	86.0	84.5	83.5	80.5	80.4
Total[4]	44	25,141	85.9	83.9	86.3	83.9	90.1	91.8	88.9	88.7	87.4	85.4	86.4	84.0*	84.1*

[1]Insofar as possible hospitals for tuberculous and mental patients are excluded as well as hospital departments of jails and other institutions. The census data are for the most recent month. [2]Including bassinets, in most instances. [3]Includes only general hospitals. [4]The occupancy totals are unweighted averages. These averages are used in the chart above. *Preliminary report.

THE MODERN HOSPITAL

A Monthly Journal Devoted to the Construction, Equipment, Administration and Maintenance of Hospitals and Sanatoriums

VOLUME 45 NOVEMBER, 1935 NUMBER 5

An Administrator and His Public*

By A. C. BACHMEYER, M.D.
University of Chicago Clinics, Chicago

THAT the hospital is an essential institution and a vital factor in social and economic life is generally recognized.

Designed to serve the needs of large numbers of the public, the service it renders is based upon the needs and demands of those who are potential patients. The institution is also in the largest measure dependent upon the support of the public and must be responsive to public demand and opinion.

Among the many lessons which these years of economic stress have taught, a major one has been the fact that no hospital can exist entirely unto itself. Though it be the only hospital and especially if it be one of a number in the community, it cannot disregard the public or its fellow institutions. The time has passed when an institution can develop a program of service, of construction or other expansion without careful consideration of the needs of the public it serves and of the other institutions and agencies serving similar or related purposes.

Rather than the development of service or other programs based solely on the ambitions and desires of individuals interested in a single institution it is essential that the needs of the community and the services of all other hospital, health and welfare agencies be taken into consideration. Because of the functions it performs, because of its contacts with so many phases of the community's life, the hospital should have a part in all plans designed for the improvement of health and social conditions. The many difficulties, primarily of an economic nature, that confront hospitals at the present time emphasize the necessity for community planning and the need for promoting favorable relations between the institution and the public.

The hospital has become the major and almost the sole agency through which the medical profession can render adequate service to the patient in time of serious illness or injury

The responsibility for establishing proper relations with the public and with other social and health agencies naturally devolves upon the administrator as the executive head of the hospital.

Large numbers of the public are constantly passing through the hospital who, so far at least as the administrator is concerned, may be spoken of as the unorganized public. This group is represented by patients, their relatives, friends and associates, by the employees of tradesmen, and the

*Read at the meeting of the American College of Hospital Administrators, St. Louis, September 29-30.

large number of visitors who constantly are entering the hospital. Important public relations are established through these individuals, many of whom belong to organized groups in the community.

Incidents which they witness, conversations in which they engage or which they overhear as well as their own experiences often form the subject of their discussions with their associates. These recitations often react to the benefit or hurt of the institution. While seeking channels through which to bring the hospital to the attention of the public and through which to mold a favorable public opinion, hospital executives often overlook this group, one of the potential agencies for such a purpose. Efficient, sympathetic service to the patient; kindliness, patience and courtesy on the part of every member of the institution's personnel; good judgment and an understanding of human relationships in meeting and interviewing this unorganized group of the community will go far in building the hospital's reputation. The administrator has a definite obligation and responsibility in this connecton. In this sense his public relations begin within the doors of the institution. The results of his efforts may be intangible but they are nevertheless real.

Building Community Good Will

As has been indicated, the hospital cannot stand alone but must integrate its activities with those of other hospitals, health and welfare agencies in order to meet properly the needs of the community. The administrator should therefore be informed concerning the organized health and social agencies of his community. He should know personally the executives of all such agencies, attend their important public meetings and confer with them as often as possible. Experience has shown that when an individual and especially one who holds a responsible position evidences an interest in the work of a social or health agency his participation in the affairs of such an agency is welcomed. If such an individual indicates a willingness to cooperate, is genuine in his interest, does not seek to exaggerate his own importance, appear overly ambitious or endeavor to force his own views, his counsel and assistance will be eagerly sought.

The administrator should take advantage of every opportunity to work with both public and private health and welfare agencies in his community, endeavor to understand their viewpoint and their purpose, be cooperative and willing to join in discussions and in the formulation of plans to meet the community's needs. Where hospital councils and councils of social agencies exist, it is his responsibility to participate in their activities. Opportunities for leadership will be afforded which the able, progressive executive will be prompt to seize to the benefit of his institution.

The divisions of the public to which reference has been made bear direct relation to the hospital and some contact with them cannot be avoided. The administrator's attitude toward them is of primary importance.

The Press Can Be a Powerful Ally

Another public agency of equal importance is the public press. The administrator frequently encounters difficulty in establishing satisfactory relations with press representatives because of inhibitions and fears largely the result of a lack of understanding of the restrictions placed upon publicity by the ethics of the medical profession. The hospital executive should be thoroughly conversant with the code of medical ethics in this respect. The public press is a powerful and valuable agency whose good offices are in most instances readily available to the hospital. Hospital executives usually recognize the educational value of the press but, through lack of understanding, fear to use it or for one reason or another shy away from conversations with editors or press representatives.

Newspaper editors, if not their representatives, the reporters, are cognizant of the ethics of the medical profession and except in isolated instances will readily observe the rules. Frank discussions with editors and reporters will usually result in clear understandings and proper working arrangements. Reporters are employed to obtain news items and their insistence at times is entirely in the line of their duty. The hospital executive must protect the interests of both patients and institution but experience has shown that press representatives are as capable of exercising discretion and good judgment as are any other human beings and a frank recitation of all facts in a given case is usually the better policy.

Giving the Reporter a Chance

When possessed of all of the facts in a given case the news writer can do justice to all concerned, whereas evasion or concealment of fact may react to the hurt of the institution. The establishment of favorable relations with the press is not a difficult matter and the administrator will find such relations of great value in promoting the interests of his institution. His dealings with the press must be fair and above board and must take into consideration the interests of other hospitals and allied agencies in the community.

There are numerous other organizations and

groups that take an active interest in hospital and health activities though their primary purposes may be of an entirely different nature. Among such may be mentioned civic groups, such as boards of trade or chambers of commerce, men's and women's luncheon clubs, parent-teacher associations and neighborhood associations; church organizations; fraternal groups; labor organizations and social groups, such as the junior league and similarly organized bodies of young women and young men.

Many of these have given great aid to hospitals on repeated occasions and some take a continuing interest and are constantly active in matters having a distinct relation to hospital activities. The wide-awake and able administrator will foster favorable relations with as many of these associations as possible. Through them as well as through social agencies and educational institutions, opportunities to give addresses and otherwise to tell of the functions and services of the institution will be afforded. By taking full advantage of these opportunities the executive may inform the public concerning hospital and health affairs.

An enlightened and understanding public is the institution's best ally in times of stress and such a public will be quick to protect the hospital's interests. Personal membership in organizations of this type will be helpful, but it is not essential that the hospital administrator be a "chronic joiner" and a member of every organization that extends an invitation to him. He should join such as have a special appeal to him, in whose program and purposes he has peculiar personal interest, but not with a deliberate intent to promote his own interests. It is, of course, important that he avoid any alliances that would be to the detriment of his institution's or his own interests.

Utilizing Auxiliaries

There are few institutions that do not have some type of auxiliary organization interested in their work. With proper planning such organizations have great value for the hospital. The competent administrator will foster the interests of such associations and diligently plan for their activities so that his institution will profit to the greatest extent.

The large number of individuals with whom the executive is brought into personal contact will afford many opportunities for friendships and social relations through which recreation and relaxation are provided. The executive should be circumspect in choosing his associates and friends. He should be careful not to become involved in entangling alliances that in any way may interfere with the impartial performance of his duties. Social activity, though it should never be sought for ulterior motives, will often prove helpful in the conduct of business affairs.

Making Surgical Trays Available Promptly

Among the most important daily tasks of the hospital's resident medical staff are the collection of blood and gastric specimens and the performance of dressings in the surgical departments. To this end, there must be promptly available adequately set up trays so that the time of the physician and nurse will be conserved. The situation often is complicated by the fact that physicians are inclined to request that special types of trays be set up in order that they may properly perform minor surgical procedures. Nothing is more exasperating to the average doctor than to be required to wait from fifteen minutes to a half an hour for the arrival of a tray.

Two systems generally employed to meet this need are described by the medical superintendent of a large Pennsylvania hospital. The first contemplates the presence on each private floor and on each ward of a series of trays, such as dressing, hypodermoclysis, blood testing, enteroclysis and other special types. Under this plan, there must be available duplicates of the various standard trays so that physicians who wish to perform the same type of work at the same time will not be delayed. Nurses are not always careful in seeing that needles are in good condition and that all articles required are on the tray. This often causes delay which may lessen the efficiency of service.

The second system, which perhaps is less frequently employed, is a central tray room in which several of each type of special trays are available at all times. Some persons feel that this system does not further the education of the nurse to the same degree as a system under which she is required to prepare and sterilize all the trays employed on the department to which she is assigned. There is much to be said, however, in favor of the central tray system. It is consonant with the approved plan of the centralization of hospital effort, such as has been so successfully carried out in the central sterilizing room and central supply room.

The advantages of this plan outweigh its disadvantages, according to this authority. If the hospital is well supplied with syringes, basins, needles and dressing instruments, the ward tray system may function satisfactorily provided there is proper supervision. On the other hand, it is questionable whether the ward tray system can possibly function as economically as a system where one group of persons is responsible for the preservation of property, for the completeness of the set-up and for the sterilization of each tray. If proper physical facilities are available and if the nursing personnel and its adjuncts are adequate, the central tray system is perhaps the best.

Whatever system is employed, the doctor must be promptly supplied with the materials and the instruments which are necessary for the efficient performance of his work.

Dr. Clarence O. Cheney, President of the American Psychiatric Association.

Foreword to the Series on Mental Hospitals

THERE are features connected with the operation of a hospital for the mentally ill which are peculiar to that type of institution, and administrative problems which are common to all private and public institutions that are engaged in carrying on this kind of work.

A series such as the one contemplated by The MODERN HOSPITAL, under the auspices of the American Psychiatric Association's Committee on Public Education, should be of interest and value to hospital administrators generally and administrators of hospitals that serve the mentally ill especially.

With an investment of millions of dollars in physical plant throughout the country, and with the physical and mental well-being of the half million patients dependent on efficient and far-sighted management, any contribution which tends to make our methods better or to help disseminate information which will help our hospital administrators should certainly find an interested and receptive audience. — CLARENCE O. CHENEY, M.D., President, American Psychiatric Association.

That New Mental Hospital

By FREDERICK W. PARSONS, M.D.

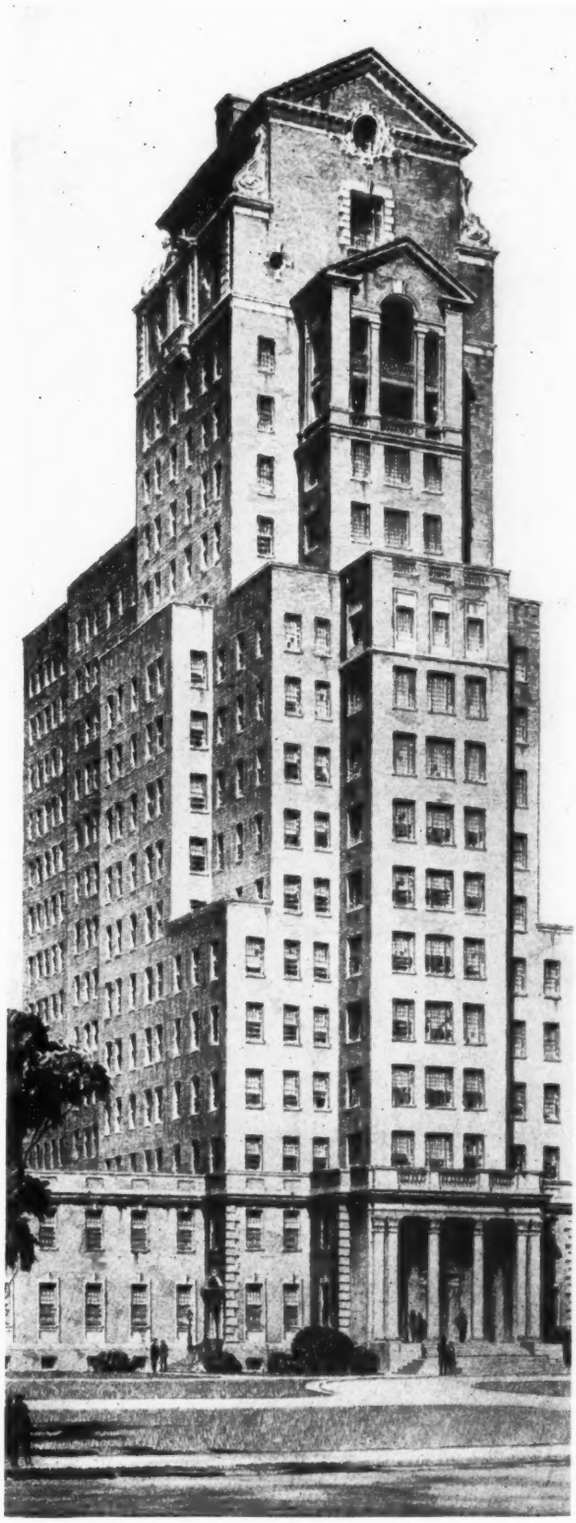
Commissioner, New York State Department of Mental Hygiene, Albany, N. Y.

HOW large a hospital for mental cases one should plan for sometimes becomes a perplexing question. The easy answer that it should be no larger than is needed does not completely satisfy the administrative officer upon whom falls the responsibility of fixing the size of the institution and the simple expedient of planting a seed and letting it grow is open to objections. A better way is to seek to determine the present need, that of the immediate future, and plan accordingly.

One can never determine with any degree of accuracy the facilities which may be demanded many years in the future, but in settling the size of an institution one should seek to avoid the embarrassing situation of having an institution whose population increase in a few years has completely outstripped the resources of the power plant, the acreage, the water supply and the opportunities to dispose of sewage.

This New York State has not always been able to avoid. In twenty years an unanticipated real estate development brought a million people into the vicinity of one of its hospitals, the result being an acute shortage of land and a building site more crowded than is desirable. The situation was somewhat helped by reducing the size of the district and dividing the admissions, but in the light of present knowledge it is easily seen that a wiser decision would have been to plan a larger hospital and to locate it where it would not have so rapidly become the center of a built-up residential neighborhood. Aside from the unusual circumstances prevailing in the cited instance it generally is possible to determine to a fair degree of accuracy the proper size of an institution.

The first step is to determine the district which the hospital is to serve. Having that, the population of the district is easily learned. Federal census figures are available showing, for all parts of the country, the number of institutional mental



Diagnostic clinic, sick and infirm patients' building, Brooklyn State Hospital.

cases for each 100,000 population. That is not the complete answer, for allowance should be made for the fact that when a new and needed facility is provided it is called upon to meet a greater community demand than was apparent before the facility was created. That increase varies widely. Where the accommodations were inaccessible or grossly inadequate a higher percentage should be anticipated and lower if the reverse is the case. In most communities in New York State an increased demand of about twenty-five per cent can be looked for.

Having ascertained the total number likely to be accommodated one should anticipate a complete numerical turnover every five years. New York State has found that period to be the average duration of institutional residence of those who were discharged or died. The admissions, however, exceed the combined deaths and discharges. The experience of New York State indicates that for every one thousand patients residing in a mental hospital of a size which suits its district there will be 250 admissions each year and about 200 deaths and discharges. There is therefore an annual growth of five per cent for which allowance should be made.

Theoretically, of course, in a district with no population deviations, the hospital should accumulate a reservoir of patients whose deaths and discharges would provide accommodations for the admissions. That desirable situation has never been attained in New York State. The more the state does the more it seems to be asked to do. New York State's patient population of sixty thousand patients produces annually about twelve thousand deaths and discharges. This does not provide accommodations for fifteen thousand admissions.

Twenty-five years ago when the institutional population was approximately half of what it is now nearly the same ratio prevailed between admissions and discharges, but the increasing public use made of all kinds of hospital resources has brought into the picture a somewhat different set of factors. Other changes, not to be foreseen now, are sure to develop in the future.

ROCKLAND STATE HOSPITAL
INFIRMARY BUILDING
Willard, Commissioner of Architecture

Every state has different conditions to meet. What is listed below applies neither to a densely populated, large and rapidly growing metropolitan city, such as New York, nor to a sparsely settled agricultural community. In a fairly closely settled state, such as is New York outside the metropolitan district of New York City, a hospital of approximately two thousand patients, the center of a district having a radius of seventy-five miles, near a small to moderately sized city, enough level ground to permit an orderly arrangement of the buildings, a possible water supply, facilities for easy sewage disposal, railroad switch opportunities, good arable land of five hundred or more acres are all desirable objectives to be sought. Many compromises probably will have to be made but some of the desirables should be attainable.

Having determined the size of the prospective hospital, it becomes necessary to consider the number of the various types, behavioristically classified, for whom accommodations will have to be provided. This varies with the community to be served. In the main those districts with few inhabitants per square mile tend to produce a higher percentage of patients with gross behavior abnormalities. In thinly settled districts mild departures from normal behavior pass unnoticed but in crowded cities slight deviations call for segregation.

The figures given herewith are not for universal application. They represent approximations. They will have to be modified to meet local conditions

View of the Pilgrim State Hospital at Brentwood, N. Y., showing the admission and diagnostic center and the acute medical-surgical building. Below is reproduced a model of the entire institution.

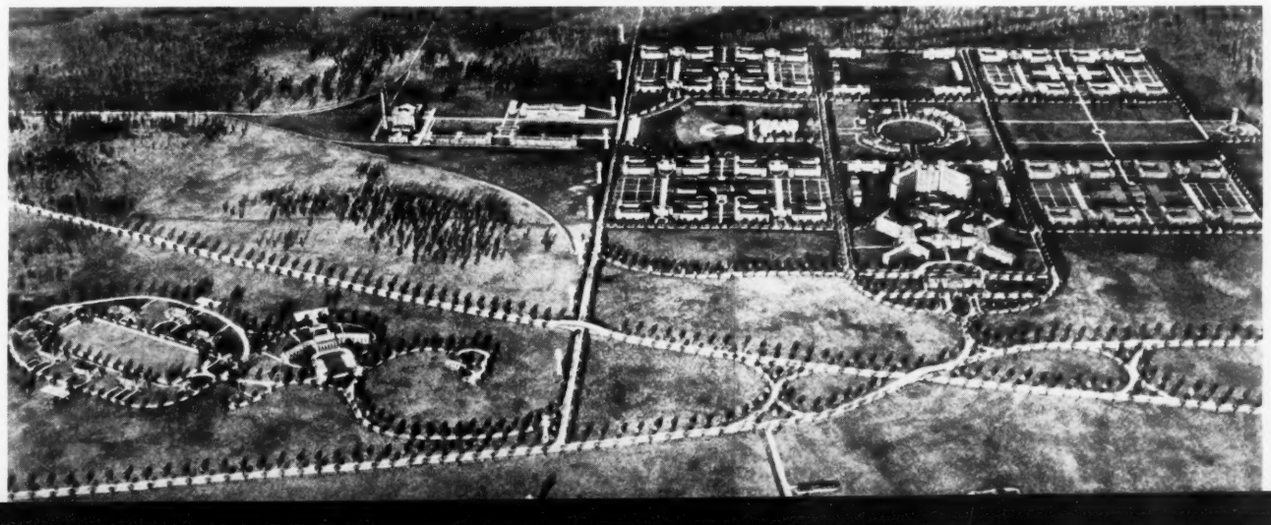
and also perhaps by the passage of time. For example, there has been a noticeable increase in the number of aged and feeble patients with the lengthening of the age span and with the growing tendency to send to mental institutions elderly persons who, if they were not cared for at home, formerly went to institutions other than those devoted solely to mental cases.

No mental hospital should be without a reception building in which all patients are admitted. Its capacity should be 33 per cent of the annual admissions. A building of that size will provide for an average residence of four months, an interval long enough thoroughly to observe every admission. Many will pass through, having stayed but two weeks or less, and in that group will be most of the long standing dementia praecox patients, those included in the senile-arteriosclerotic classification, and others presenting no psychiatric or medical problem. A building of that size will permit recoverable patients to remain for long periods. It is generally thought to be unwise to let hopeful cases pass from the intensive care most likely to be achieved in that portion of the institution set apart for the recently admitted.

A three-story admission building provides facilities for the care of all types. The common practice is to admit all or nearly all of the patients to the second floor ward, reserving the third floor for the actively disturbed, which generally can be the smallest ward and still have the larger floor area per patient. That arrangement provides accommodations in the admission building for the active cases, where they properly belong, when so frequently, because of insufficient provisions, noisy, recoverable patients have to be sent to continued treatment buildings.

The first floor can be reserved for convalescent patients and those in whom recovery is not to be expected, but whose behavior and whose former place in life entitle them to special consideration. The operating room has no place in an admission building. It is better not to complicate the psychiatric work by the demands of the operating room and the special nursing care required by surgical cases. Small wards, attractively furnished, and a high percentage of single rooms should be provided in the admission building, even if reductions in those features have to be made elsewhere.

One does well to provide about 22½ per cent of the total accommodations (excluding those in the reception building) for the depressed and disturbed in the continued care group. Small dormitories for easy observation are thought to be better for the depressed cases, but for the chronic disturbed one can avoid most of the broken sleep caused by noisy patients only with a high percentage of single rooms. A minimum of 50 square feet of day space should be provided for each disturbed patient and as they are taken out of doors only with difficulty, accessible porches are desirable. It is good practice to limit the size



of the wards for the disturbed to fifty patients.

The quiet and moderately disturbed patients will number about fifty per cent of the institution population. For this group large wards and large dormitories are not particularly objectionable, although smaller wards are better. One cannot say these patients do badly if a ward in a large hospital has a capacity for 100, but the dormitories should be broken up into smaller units, a few single rooms should be provided for emergencies, and as a reward for better behavior more than one day room is a welcome accessory.

For the feeble group, which includes those patients unsteady and likely to fall, as well as those continually confined to bed, there is no objection to a multistoried building if it is of fireproof construction. Elevators make vertical travel as easy as horizontal and construction savings are made possible by tall buildings. The feeble group will usually constitute about 22½ per cent of the total.

Planning the Tuberculous Unit

If the hospital is large a unit for tuberculous patients is necessary. The trend is away from the simple one-story, lightly constructed building, for which only a short period of use is contemplated. In New York the tuberculous patients number about 3½ per cent of the total. Perfectly satisfactory accommodations for patients suffering from tuberculosis can be constructed on the roof of a building devoted to nontuberculous patients and this has been done when it was necessary to provide accommodations only for 100 patients. The highly developed facilities commonly found in recently built and expensively equipped hospitals for tuberculous patients are hardly called for in a mental hospital.

Except for a possible farm colony all the types for whom institutional care is desired are now accounted for except the acute medical and surgical, who in New York State comprise about 1½ per cent of the population. In smaller institutions these are cared for in single rooms or in small dormitories, a part of wards devoted to other types, but in the larger institutions we have provided complete general hospitals in which provision also has been made for the acute medical and surgical illnesses among the employees.

This acute medical and surgical hospital is the logical place for the diagnostic center which comprises rooms for all the medical specialties, the x-ray and the dentist. These scientific centers are a great help in keeping alive the medical interest and if specialists are available in the community they will willingly attend if facilities are provided.

One does well to strive for an integrated institution, and widely scattered buildings, sometimes necessary because of the conditions of the site, are not to be thought of as an objective. Buildings can be grouped without having sacrificed light and air by being too close and in the grouping some consideration should be given to flow lines. It is logical to have the admission building the structure nearest the main approach, and the acute medical-surgical building and the infirmary approximating the institutional center.

We seek to have as few kitchens as possible and plan to take the ambulatory patient to the food rather than to bring the food to the patient. Cafeteria service seems to be the best present arrangement. Cafeteria dining rooms need be only one-third as large as a dining room in which all the patients can be seated at one time. The saving thereby resulting can be used to supply corridors leading from the wards to the dining rooms.

Except for employees, who because of their duties necessarily have to trickle into their dining room, a cafeteria service for less than fifty patients is rarely economical. If two or three hundred or more patients can flow through a well designed and intelligently operated cafeteria the service of food to large numbers of patients reaches levels of excellence attained by no other system of food service available to the average institution superintendent. It can be used by 90 per cent of the ambulatory hospital population, and even with patients whose behavior would lead one to think cafeteria service unsuited.

Cafeteria Service Has Many Advantages

Unfounded complaints of the quality of the food and the inadequacies of its service entirely disappear with the inauguration of cafeterias, patients have hot food, they can have a choice and as a result of an opportunity to decline certain articles the waste is markedly reduced. After the introduction of cafeteria service into an established hospital two striking events have become manifest. Unless the purchased quantities of staple articles of food are reduced the storeroom stock becomes unduly large; and, second, the swine herdsman reports that the kitchens no longer supply him with enough food for the pigs. Money spent for the remodeling of kitchens and dining rooms in numberless instances would be recovered by the resulting savings.

This sketch is based on the experience of a single state and represents the present view of one person. Although New York has the largest mental hygiene problem in the country, and perhaps in the world, it is realized that conditions elsewhere may render inappropriate what in one place seem to be desirable practices.

How Shall Laboratory Personnel Be Trained?

By KANO IKEDA, M.D.

Director, Department of Laboratories,
Charles T. Miller Hospital, St, Paul, Minn.

A new profession has recently come into being — that of the laboratory technician. It behooves every hospital which considers first the welfare of the patient and the interest of the attending physician to select with care the technical workers whom it employs in its clinical laboratory

A FUNDAMENTAL requirement of a standardized hospital is the maintenance of a clinical laboratory organized and conducted to afford practical aid in the diagnosis and care of the patient. The American College of Surgeons in its standardization program does not demand that such a laboratory in the average general hospital be a teaching or research laboratory. Nor does it require that the laboratory be directed by a full-time pathologist. Such would be obviously not only impractical but impossible on the part of the small hospital. It does insist, however, that the hospital clinical laboratory be equipped and manned to render reliable service and that through special arrangement the expert service of a pathologist be available at all times. It is the intention of the college, as I understand it, to insist that all hospitals in this country and Canada provide the kind of laboratory service essential in the scientific practice of medicine, regardless of location or type of population.

The laboratory technician is a comparatively new creature. Complexity of modern laboratory practice has compelled the pathologist, through necessity, to employ nonmedical technical assistants to assist him to perform time consuming and exacting technical work entailed in his practice.

Not many years ago, such technical assistants were found only in large medical laboratories, but with the advent of the hospital standardization program and group medical practice and with the greater appreciation of laboratory diagnosis by recent graduates in medicine, there has come into being a new profession, that of the laboratory technician. His function is to perform laboratory tests and determinations, either for the pathologist who must now devote all his time to diagnostic and consultation work or for the practicing physician who possesses neither the training nor the time to do them. Hospitals, clinics and individual physicians have come to employ these technicians and in a few instances have installed them actually as their laboratory director.

A boom for laboratory technicians was soon anticipated. Promoters and commercially minded men at once sensed the opportunity and organized schools for the training of such technicians. As a result hundreds of ill-trained and poorly qualified laboratory assistants were soon seeking and obtaining positions as trained laboratory technicians. The situation was not to be long tolerated. It had to be remedied in order to protect the principles of hospital standardization and safeguard the practice of laboratory medicine from exploitation and lay interference.

Objectives Sought

In 1928 the American Society of Clinical Pathologists created a board of registry of technicians. The objectives of this board are:

1. To establish the minimum standards of educational and technical qualifications for various types of laboratory workers.
2. To classify them according to these standards.
3. To receive applications for registration and issue a certificate of registration to those who meet the minimum standards of requirements.
4. To register schools which offer an acceptable course of laboratory training.

The American Society of Clinical Pathologists has fixed the minimum educational prerequisites for the laboratory technician to be a year's work in a recognized college including chemistry and biology. This may be raised to two years' credits including chemistry and biology, in 1938. The question of what should be the minimum prelimi-

nary education a laboratory technician may possess has been carefully studied by the board which believes that as a general rule high school education alone is no longer sufficient for a qualified laboratory technician.

While there are a few pathologists who still believe that a high school graduate makes an excellent technician, a large majority of laboratory directors are now of the opinion that their technician should possess a higher educational background, especially a working knowledge of the fundamental sciences. Many prefer college graduates. The reason is obvious. Today, we have many a complicated test or determination which is routinely carried out by the laboratory and which often demands fundamental knowledge in chemistry or biology on the part of the technician. When the technician is required to do only work of a routine nature, such as the blood count or urinalysis, throughout the day, under constant supervision, in a factorylike fashion, intelligent high school girls may serve the purpose. The average hospital clinical laboratory, however, must look to the technician not only for the ordinary skill of a trained manual worker but for initiative and for fundamental understanding of individual technical procedures. This is more apparent in the smaller hospital laboratory where only one technician is employed, often without the constant supervision of a qualified pathologist.

Where Training Is Offered

Laboratory technicians are being trained in several types of institutions: (1) the commercial school for laboratory technicians; (2) the private commercial laboratory usually operated by a pathologist; (3) the private laboratory of a physician or a clinic; (4) the public health laboratory; (5) the hospital laboratory; (6) the regular course in medical technology in a university or college. The American Society of Clinical Pathologists believes that the training offered by the first four is inadequate and often undesirable.

The most desirable training of technicians is admittedly afforded through a two or four-year course in medical technology offered by universities and colleges of recognized standing, in conjunction with large approved general hospitals. Unfortunately there are only about ten or twelve such schools in the United States which fall far short of meeting the existing demand for qualified technicians or of accommodating the number of prospective students which has not diminished in the years of economic depression.

There are in this country perhaps 200 or 250 clinical laboratories of general hospitals which maintain courses of training for laboratory technicians. A few of them conduct a course equal if not superior to any of the university courses. Many others are training technicians who can readily meet the present minimum requirements of the American Society of Clinical Pathologists. Thus, there are today a number of general hospitals of recognized standing which conduct a more or less systematic course of instruction in laboratory procedures to a limited number of students, under excellent supervision.

Essentials of Training

The majority of these hospitals have subscribed to the minimum essentials for a course of training proposed by the American Society of Clinical Pathologists. These essentials are:

1. The director shall be a graduate in medicine and a clinical pathologist of recognized standing.
2. The technical staff shall consist of a sufficient number of trained specialists or registered technicians, capable of teaching, demonstrating and directing the work of the individual student.
3. The yearly enrollment shall not exceed more than one student to each member of the teaching staff (except the regular college course).
4. The hospital shall have a bed capacity for not less than 100 patients and an average occupancy of seventy-five or more per day.
5. The minimum educational prerequisites shall be (a) high school graduation, and (b) credits of one year of college work including chemistry and biology.
6. The minimum length of the course for training shall be not less than twelve months, consisting of a rotating or departmentalized service with the minimum 300 laboratory and a sufficient number of didactic hours in each two-month period.
7. The instruction shall include (a) didactic period, (b) text assignment, (c) quiz hour, (d) periodic written examination, (e) practical demonstration, (f) practice period and performance of tests under supervision.
8. There shall be adequate equipment and space, as well as a sufficient number and variety of specimens, to meet the added requirements of training and practice of the students.
9. Commercial advertising is considered unethical.

Under this plan, the American Society of Clinical Pathologists has already approved seventy-six hospital laboratories and has on file other applications for approval, many of which have met the minimum requirements. In a survey recently published, I found that there has been decided improvement in this type of instructing laboratory technicians. For example, the number of laboratories requiring one year of college work for

entrance was increased from 5.5 per cent (of 127) in 1931 to 31.6 per cent (of 136) in 1934, and the number of those requiring only the high school education dropped from 64 per cent in 1931 to 36.1 per cent in 1934. In the matter of the length of the training period, the number requiring a period of twelve months rose from 37 per cent in 1931 to 60 per cent in 1934 and those requiring a six months' period dropped from 36.7 per cent to 10 per cent.

The manner of instruction by these hospital laboratories differs somewhat according to the type of the institution and the extent of the facilities. Three types of instruction with various modifications may be mentioned. The first and the most desirable, although scarcely suitable for the average hospital laboratory, is one in which a regular schedule for didactic lectures is carried on daily in addition to assigned work and actual practice in the laboratory.

Advice to Laboratory Directors

Only a few larger hospitals and some of those affiliated with medical schools adhere to a plan of this kind without disrupting the routine program of the laboratory service proper. The present endeavor is so to counsel the laboratory directors as to encourage them either to accept for training only those who possess necessary college credits in laboratory sciences which obviates prolonged didactic hours while in training or to seek an affiliation with a local university or college to cooperate in a course in medical technology.

The second, the common and accepted mode of training, followed by many of the laboratory directors, is conducted somewhat as follows: The students are enrolled individually at stated intervals and assigned to a department for a stated period, to be transferred or advanced to a second department on completion of training in the first and so on. The entire laboratory is departmentalized into, say, six units and the student assigned to each for two or three months under the director or technician in charge of the department whose duty it is to arrange didactic talks, assign lesson studies, conduct periodic quizzes and examinations as well as to demonstrate and supervise performance of tests.

The third plan of "training" which is employed by a large number of hospital laboratories, particularly those employing one or two technicians and a part-time pathologist, is strictly on a practice basis and usually follows no organized schedule. Some of these are the laboratories which enroll "students" in order first to extract their free service as helpers, in return for the opportunity of receiving instruction in routine technique.

Such an arrangement is practiced particularly by those clinical laboratories in which there is a shortage in personnel and the "students" are taken in primarily to render the menial service which otherwise demands one or more additional paid employees. In a few instances, such a practice is apparently encouraged by the hospital administration. While the trainee may assist in routine service of the laboratory as a personal assistant to the supervising technician and such assistance may be claimed by the laboratory, the primary objective of the course should never be neglected or forgotten; any service rendered by the student should be considered incidental.

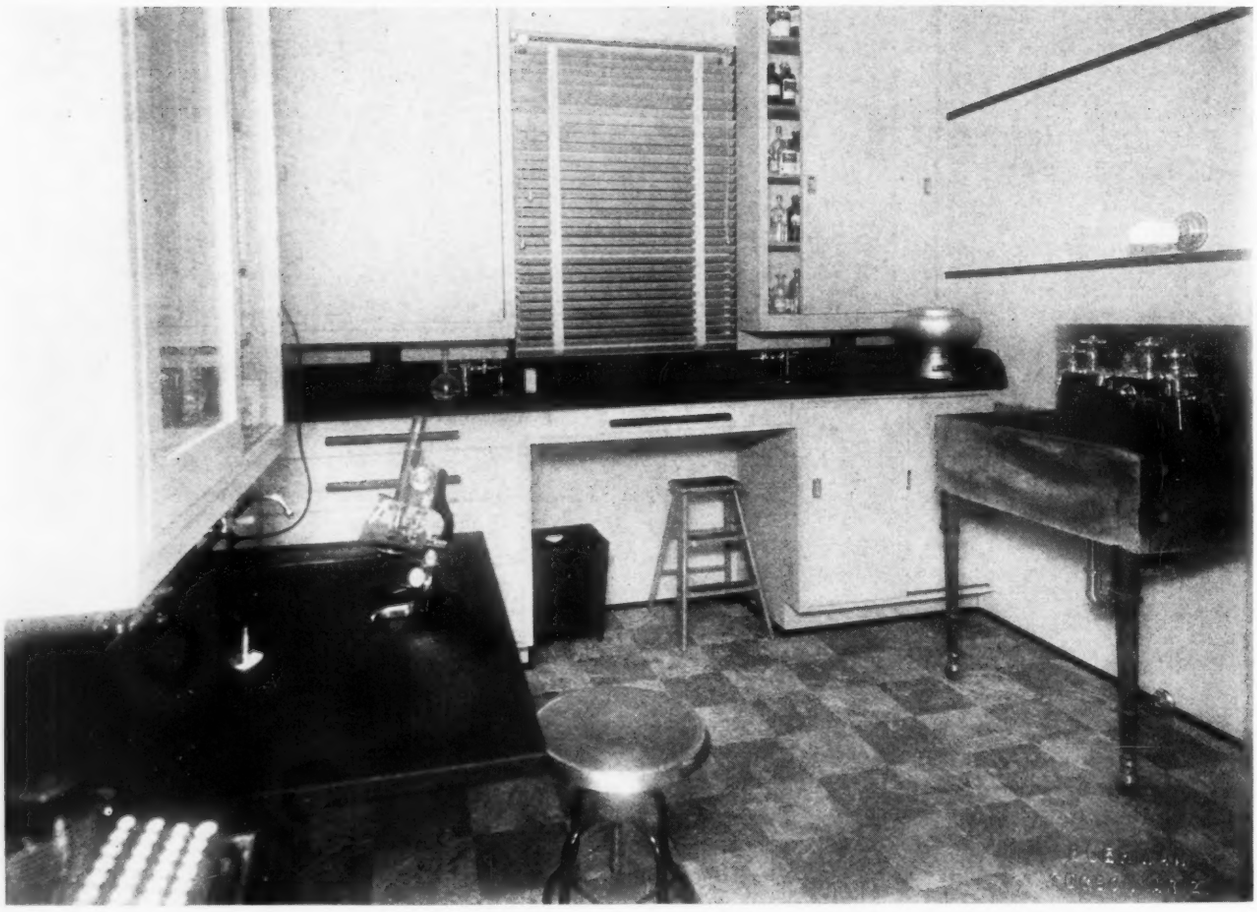
Recently, a scheme has been advanced by certain commercial schools for the so-called "internship" for technicians who serve a period of six months in a hospital laboratory without compensation. This plan undoubtedly appeals to certain well meaning and unsuspecting hospital administrators eager to reduce operating expense. A word of caution must be given to those who may be tempted to accept such a seemingly admirable offer of free service. Hospital administrators would do well to consider carefully whether or not such internship of poorly trained technicians would be for the good of the laboratory service and in the interest of the patient, particularly if no intimate supervision of a qualified pathologist is had in the laboratory. It is also well for them to learn if the prospective technician-interns are eligible to become registered technicians.

2,500 Registered Technicians

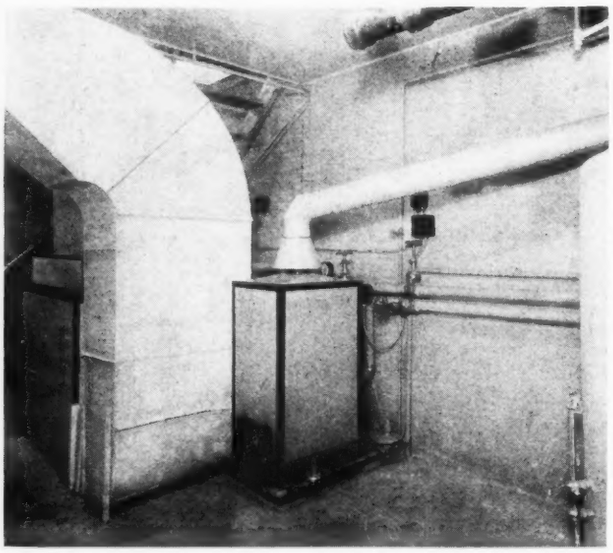
Perhaps the most valuable contribution the American Society of Clinical Pathologists has made through its board of registry to the practice of laboratory medicine, is its work of registering qualified technicians who meet the minimum educational and technical requirements and who successfully pass the examination conducted by that board, bi-annually. There are today, approximately 2,500 laboratory technicians who hold a certificate of registration from the American Society of Clinical Pathologists.

The American College of Surgeons has insisted that hospitals employ only registered technicians in clinical laboratories. The American Medical Association has also come to the active support of the American Society of Clinical Pathologists in this undertaking. Plans are being contemplated whereby the approval of the hospital laboratories conducting a training course for technicians will be given jointly by the council and the board of registry, according to the minimum standards to be formulated by these two bodies.[1]

[1]Read before the regional conference of the American College of Surgeons, St. Paul, Minn.

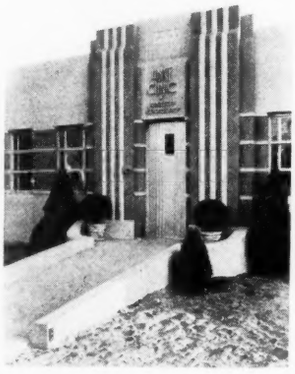


The main feature of Wyatt Clinic's diagnostic laboratory (above) is a low solid two-person microscope table, equipped with a water tap, gas and electricity. The table faces a narrow wall cupboard with glass and sliding doors. The air conditioning room (below) is in the basement. Horizontal cover strips are used on the interior of the building. Cove base and door and window trim are designed to miter with these strips.



Our First Year's Experience With Air Conditioning

By BERNARD L. WYATT, M.D.
Wyatt Clinic, Tucson, Ariz.



THE September, 1934, issue of The MODERN HOSPITAL carried the first report on the initial unit of the Wyatt Research Foundation, the research laboratories building of the Wyatt Clinic, Tucson, Ariz. A further technical analysis, with illustrations, appeared in the June, 1935, issue of the *Architectural Forum*.

Readers of The MODERN HOSPITAL were promised a further report, at the expiration of a year, with regard to the success or failure of this experiment in building technique, together with a statement of the operating cost of the air conditioning system. This brief article has been prepared in fulfillment of that promise.

The steel facing, applied to the insulation by a patented process, has thus far shown only minimal effects from expansion or contraction. Moreover, the finish of sanded cement paint has provided an entirely adequate protection against corrosion.

Special Window Glass Is Used

The double glazed windows with a 1-inch air space between panes and the use of a special intercepting glass for the outside panes have contributed greatly to the success of the air conditioning equipment.

The 4-inch air space in the exterior walls, which provides an air-to-air conductance of approximately .079 B.t.u. per hour, the roof conductance of approximately .069 and the window conductance of about .453 have been other factors, whose importance cannot be emphasized too strongly.

The total cost of the building was $0.73 a cubic foot, of which amount 28 per cent was required for the mechanical and foundation work.

The specifications for air conditioning called for a constant interior climate of 80° to 85° F. in summer and of 70° to 72° F. in winter. These requirements have been met completely, despite summer temperatures of 110° F. or more, with humidity figures of 5 to 15 per cent, or wet bulb readings of 65° F.

Water is circulated and recirculated through an especially designed evaporative cooling tower, which brings the water to within 2° F. of the wet bulb temperature. This water is then circulated through large radiators especially designed for cold transfer.

2,500 Cubic Feet of Fresh Air a Minute

All fresh and filtered air is circulated within 2° F. of the water temperature, although the air never comes in contact with the cooling water. Thus it remains absolutely dry. Oversized blowers are run at low speed to ensure absolute silence. The outstanding advantage of this "natural principle" installation is its ability to deliver continuously fresh, dry and filtered air at an operating cost of but one-fourth that of refrigeration cooling. Only one horse power is used for the cooling of the entire building. Twenty-five hundred cubic feet of completely fresh, cooled and filtered air are delivered every minute.

For heating, a natural gas fired boiler is used to supply water at 120° F. to the same radiators that are used for cooling; also, the same blowers are used to circulate the warmed air, although any percentage of air desired may be recirculated in winter time. The parched baked effect of superheated air is completely avoided.

Arthritic patients prefer a dry climate, and humidification in winter is contra-indicated. In summer, the natural dryness makes dehumidification unnecessary. The entire air conditioning system is completely automatic in operation.

The operating costs are $0.75 a day for the winter months and $0.30 a day for the summer season.

It is believed that this building clearly portrays the future trends of technical progress and in the completion of our building program no changes in either construction methods or materials are contemplated.

Should Nurse Education Be a Basic

By EDGAR C. HAYHOW

Superintendent, Paterson General Hospital,
Paterson, N. J.

IT IS unfortunate that the term "nurse" has been and is applied to all types of persons from the wet nurse and child's nurse to the Ph.D. in nursing.

In the new developments in nursing education, the contention has been that the education of the nurse has an educational objective and must be approached with the same methodology and technique as other educational programs. Aims, objectives, supervision, operation and management should be a responsibility of educational authorities. All reports emphasize the term "higher education." This seems a misnomer. Higher education usually presupposes a baccalaureate degree, certainly professional education beyond the junior college level.

After careful study I believe that one or two years can reasonably be added to the secondary school curriculum for orientation courses in cultural and preprofessional subject matter as a background for the basic nurse training. The present percentage of eliminations of preliminary students for various reasons indicates the need of a preliminary term in prenursing at other than hospital expense. Whether this orientation course should be a part of a curriculum on the college level or a postgraduate high school course is a matter for conjecture.

Yale University offers a thirty months' course leading to the degree of Master of Nursing (M.N.), open to women who are graduates of approved colleges. It is fair to assume that this graduate student is educated beyond the "basic nurse" and trained to specialize in nurse education or administration and it is not surprising that only 2 per cent of the graduates have chosen private duty. Courses for further graduate specialization are also offered and lead to higher degrees.

The need to educate women for general duty on the hospital ward is imperative. This type of nurse service must be forthcoming if the student is to be in the hospital on a practice basis and independent nursing services are to be responsible for bedside care. While the general hospital can usually provide nurse service at less cost with a training school than with a full graduate nurse staff,[1] irrespective of cost, the preliminary education of the student nurse is rightfully an educational task and should be maintained under qualified educational auspices.

If this is so, who should bear the cost of this preliminary education?

It has been our national philosophy to divide all education into two groups — private and public. The national and state policy clearly defines general education as a public responsibility. The Morrill Act, the Smith-Hughes Act, and the Smith-Towner Bill provided federal funds to establish as part of the state educational systems, departments of agriculture, mechanical arts, vocational schools and public health under federal grants. It presupposed that these specialties have significant public purport. State universities originally designed to accommodate general cultural and teachers' training courses added various professional schools of medicine, dentistry, law, engineering and, in some instances, nursing. Specific professional schools were not included in states where the training for certain professions was adequately provided for in private institutions. Yet this does not imply that it is any the less of a public responsibility. Were no private institutions available, public ones would naturally come into being. This is the case in certain regions.

The same is true of nursing. Government hospitals now provide and maintain nurse training schools and it is reasonable to assume that tax support should be available to provide necessary nurse training for communities in the advent of the discontinuance of the existing schools under voluntary auspices.

If the Nurse Pays, She Must Charge More

To return to the original premise, should nurse education, whether it proved cheaper, more efficient, or offered more effective care in one system or another, be a basic charge to the patient? It is sound educational theory and practice to charge tuition for acquisition of knowledge. Still, if the nurse student pays in academic tuition fees, how will these fees be amortized in her charges after

[1] A Study of the Relative Cost of Maintaining Nursing Service at the Paterson General Hospital With and Without a Nursing School, Edgar C. Hayhow, Bull. Am. Hosp. Ass'n, Apr., 1935.

Charge to the Patient?

Tax support may prove necessary

training to reimburse her sufficiently for these five to eight years of training?

A college trained nurse will be on the same academic, economic and social level as other women with similar educational attainments. If it is recognized that there are two types of nurse service, it seems logical that separate institutions or at least separate courses be maintained for the training of students in these two groups: first, the college trained woman educated at her own expense in voluntary institutions for selective specialization; second, the basic nurse, with possibly a maximum of junior college training, educated at part-public expense for bedside care. The educational set-up in America is admirably fitted to apply such experimentation. Each state provides public institutions — normal schools, teachers' colleges and nonprofessional institutions on the college and university level. Junior colleges are fast becoming integrated into the educational pattern. They offer complete educational set-ups.

More Careful Selection Is Needed

At present little attempt is made for any selective admission of nursing students, consequently the percentage of separations (eliminations) is high. No attempt is generally made for psychologic, emotional or aptitude testing although the practice of prephysical examination is increasing. One director of nurses boasted of admitting twice the required number of preliminary students because of the estimated misfits and failures. This system of securing student material is costly, inefficient and boasts of no knowledge of educational theory. While practically all applicants are high school graduates, it is questionable what percentage are true college material by inclination, persuasion or innate intelligence. This whole subject of student selection would be better handled by regular educational institutions. Thorough studies of it would make excellent research theses.

Is it possible to add a postgraduate or fifth year to the secondary school system or provide for a special one-year group in the state teachers' training institutions? Yes, central grouping of preliminary students has proved its effectiveness and voluntary hospitals could well be relieved of this expense. Experience has proved that a central unit for the academic type of work is more effective and less expensive than separate and distinct units. The curriculum could be devised under the supervision of a central committee in each state and, inasmuch as these institutions have the necessary educational and physical facilities, the only added expense would be for one or two nurse instructors.

Hospitals could therefore eliminate a large part of their full-time instructor personnel and the income received from tuition would more than counterbalance the additional financial expenditure on the part of the state. The cost of housing and sustaining the preliminary student is eliminated from the hospital budget; ward maids could effectively assume the duties on the ward now assigned to preliminary students. It is expected that in individual cases such affiliations with normal schools will be opposed by either the hospital or the school or both. However, should this plan prove successful with a one-year curriculum, it could reasonably be raised to two years.

Our economic circumstances have necessitated government financial aid for hospitals. In an endeavor to lower the cost of hospital care could the major cost of educating the basic nurse be transferred as a public expense? The present philosophy of the government's relations to education could be maintained. Less overlapping of services and more effective teaching would ensue. To reiterate our previous statement — if we should eliminate all private, professional educational enterprises, at once the government would establish public enterprises. Such wholesale socialized philosophy is not advocated, however.

It should not be difficult to establish a standard

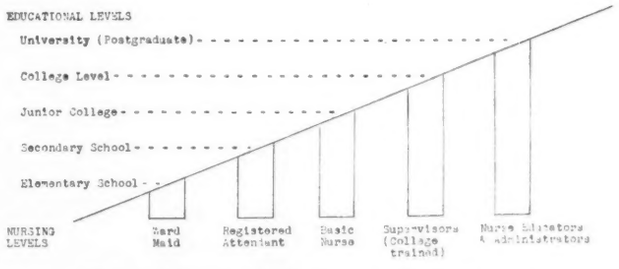


Chart showing relations of groups of nurses.

basic curriculum for nurse training if we clearly define our objectives. Let us assume that it should provide the basic training necessary to acquire average skill for the bedside and auxiliary services needed in the ordinary situation. From the

present curriculum eliminate such duties as can reasonably be assigned to the attendant or ward maid group. The curriculum for the training of basic nurses calls for certain educational processes quite apart from those employed in training nurses to teach nursing. The mere possession of a bachelor's degree does not assure a knowledge of educational theory; we may still look to our state educational departments to institute uniform standards for certification of teachers of nursing as of other subjects.[1]

For the more advanced groups combined cultural and professional courses could lead to graduate degrees in nurse education, administration and supervision. A curriculum on this level would be comparable to the required standards for teaching in elementary, secondary and college levels.

It seems logical to assign many routine duties of the bedside to an attendant group. This group is now "nursing" in the community and should be appropriately registered under state authority.[2] However, short courses of six months to one year could be established in recognized and approved hospitals for this group. Upon the satisfactory completion of this course in the simple rudiments of nursing procedure, by examination, the applicants would be duly registered.

As there is need for some of these nurses educated on a high level, so is there need for nurses with a lower level of training to equalize the load. Potential remuneration for grade levels should be in keeping with educational levels. The relations of the various groups are indicated in the accompanying chart.

It seems conclusive that one type of standard training for all nurses can hardly be applied to the various needs of our modern social life. Conditions seem to indicate the need to recommend three distinct groupings:

a. The registered attendant for women possessing no especial educational background (nothing beyond high school) who receive one year of intensive training in the rudiments of nursing and hygienic care.

b. The registered or "basic" nurse who, upon completion of a regular high school course, will receive one or two postgraduate or junior college years in academic and cultural studies to precede a prescribed course in nurse training.

c. The college woman, who by a combination of nurse training and academic instruction in various other social fields, is qualified to undertake advanced positions beyond those offered to the basic nurse.

It is further suggested that with the educational classifications so clearly defined, the standards used for training of nurses be measured by established educational formulas. Since the cost of educating the nurse is not a proper charge to hospital patients, women training as nurses in private educational institutions should pay prescribed tuition fees; other nursing schools should be maintained in affiliation with existing educational institutions at public or part-public expense. This would permit nurses aspiring for the higher brackets to pay for their education in private educational institutions. It would also still permit state institutions of higher learning to maintain nursing schools on the college level for such public and social service as the state may prescribe. Costs of educating basic nurses (at first to include the orientation and preliminary term) could be chargeable to government agencies, yet individual hospitals desirous of maintaining recognized training schools under private control could continue to do so.

[1]State School Administration, Ebberly, page 585.
[2]Nurse Education and Practice in New York State With Suggested Remedial Measures, Dr. Harlan H. Horner, p. 36.

When Buying Turkish Towels

Some practical points to consider when purchasing turkish towels are enumerated in a recent issue of *Hotel Management*. Specifications to be used in purchasing include the following:

Absorbency — Yarns should be soft-spun so that they will absorb moisture readily.

Color — White towels should be well bleached and clear. Colored areas, such as borders and name-woven stripes, should be fast to the formula used for washing white flatwork, because towels are usually washed along with white goods.

Strength — The warp should be 40 pounds per inch or better. Preferably two-ply yarns should be used for ground warp to reenforce the towel in the direction that undergoes the greatest strain in use.

Filling — The filling should be strong enough and closely enough spaced to make a stout ground fabric that binds pile loops in securely and prevents them from pulling out.

Pile Loops — These should be fluffy, spongy, absorbent, free from scratchiness and securely bound into the ground fabric.

Selvages — Selvages should be firmly reenforced so that they will endure continual use and washing without fraying, breaking or splitting.

Hems — These should be evenly and securely stitched with a good quality thread which will not wear out before the towels do. Corners should be firmly reenforced.

Stitching — Breaks in thread occur, causing the hem to ravel. Some towels show breaks in the cloth where the hems are stitched.

For conclusive tests of towels, observations should be made after from fifty to 100 washings, the hotel magazine declares. Comparisons should be made on shrinkage, texture and color.

Convalescent Serums Have Proved Their Value

By WILLIAM THALHIMER, M.D.

Formerly Director, Deutsch Convalescent Serum Center, Michael Reese Hospital, Chicago

IN THE fall of 1930, it was my good fortune to secure a fund generously donated by the family of Samuel Deutsch, to establish a convalescent serum center in his name at Michael Reese Hospital, Chicago. The center was opened in 1931.

The main desire of the donors at that time, which was before the 1931 epidemic in New York, was to provide convalescent poliomyelitis serum for the treatment of individuals suffering from this disease and for an investigation of the efficacy of this serum. Since this is a seasonal disease, the donors readily consented to utilization of the facilities and personnel of the center throughout the year for the preparation of various types of convalescent serum and the study of the prophylactic and therapeutic values of these for the common acute infectious diseases. The rapidly increasing demand for these latter serums soon caused their preparation and investigation to become the major task of the center.

In order to carry out this plan it was necessary to arouse the interest and gain the cooperation of local city and state public health authorities. This cooperation, which has continued, made possible the progress to be reported.

Michael Reese Hospital furnished rooms in its Nelson Morris Institute laboratory building, and the general laboratory and institutional facilities essential to the development of the center. The original equipment and supplies cost $6,000. The rigid technique required by the U. S. Public Health Service has been followed and this has led to their issuing a federal license to the center.

The blood is collected by needle puncture of an arm vein, after novocaine anesthetization of the overlying skin, using a closed sterile system of rubber tubes, two hole stopper, etc., into a 250 cc. heat resisting glass centrifuge bottle. After clotting and centrifuging, the serum is transferred by suction in a dustproof room into another heat resisting glass bottle, at which time samples are inoculated into six Smith fermentation tubes, and another sample is turned over to the department of bacteriology and serology, under Dr. Katharine Howell's direction, for both Wassermann and Kahn tests.

Only those serums are used for which these tests are completely negative and the sterility tests are negative after at least seven days' incubation. Then the serums are pooled, (usually thirty individual serums), 3/10 per cent of tricresol is added, and, after standing overnight, are passed through a Berkfeld filter, also using a closed system for transferring the serum in the dustproof room. The filtered serum is bottled in the usual way in the same room, in 20 cc. or 10 cc. vials. The first and last bottles are each cultured into six fermentation tubes, and an additional bottle is cultured for every 500 cc. in the pool. The serum is not released for use until the incubated cultures have remained sterile for at least seven days.

Adult Convalescents Are Source of Supply

The sources of serum for all infectious diseases, except poliomyelitis, are adult convalescing patients just before discharge from the infectious disease hospitals, or patients quarantined in their homes at the same period of convalescence and just before release from quarantine. This first collection of blood is made from the nineteenth to the twenty-first day after the onset of the illness, and only from those convalescents who have been afebrile for at least a week.

The consent of the convalescents in the hospitals to furnish blood is obtained by the resident staff. A physician and a technical assistant from the center visit the hospital two or three mornings a week, and obtain the blood from the designated patients, relieving the resident staff of this work. The contagious disease hospitals receive, without charge, one-half of the serum prepared from the blood furnished by their convalescents. Many patients furnishing blood themselves received convalescent serum treatment during their illness, and the serum prepared from their blood has proved just as efficient as that from the blood of patients who were not treated with convalescent serum.

After they return to their homes, these recently recovered individuals are requested, by letter, to

report to the center every two or three weeks for a period of four months after the date of onset of their illness. They furnish 225 cc. of blood for which they are paid $5 each time. Blood is taken only if the individuals' red blood count and hemoglobin per cent justify this. These tests precede the taking of blood at each visit. It has been found that not only can this amount of blood be furnished with safety at these intervals, but the individuals' red blood counts usually increase during this period.

Doctor Consulted Before Patient Is Approached

The names of the patients quarantined in their homes are furnished by the Chicago Health Department, as well as the names of their private physicians. Before requesting these patients to furnish blood to the center the consent of the physician is obtained to discuss this with his patient. If the physician does not desire this or states that his patient is not in good enough physical condition, the patient is not approached. The physicians practically always have consented, whereupon a physician and technician from the center go to the home, and tactfully explain the need for convalescent serum and the benefit others will derive from its use. Usually the recent patients readily consent to furnish blood, are paid $5, and the blood is drawn.

Up to the present, for practical reasons, blood has not been taken, in Chicago, from children or minors recently recovered from the acute exanthemata. If desirable this could be done after first obtaining written consent of parents. The amount of blood a child can furnish is, however, relatively small and would entail an increase in work and in cost of handling. Nevertheless, during an extensive epidemic, large children, fourteen years of age or older, and adolescents might be an important additional source.

The protective and therapeutic potency of convalescent serums for the acute exanthemata is greatest immediately after the patient's recovery from the disease. Fortunately this potency has been found to endure for at least four months (measles and scarlet fever), making it possible to secure serums in sufficient amounts to be of practical value. An important problem awaiting solution is to determine how long this potency persists after the patient's recovery. Serums can be kept at 4° C. for at least six months, and perhaps for a year, without much loss of potency.

A process is now generally available for drying serum while it is in a frozen state, the resulting product apparently retaining its original potency for a long time, possibly for years.

Poliomyelitis serum obtained up to twenty years after recovery from the disease contains specific virucidal substance.

Recently the value of poliomyelitis serum during epidemics has been questioned. In Chicago, however, with no unusual seasonal incidence, the results indicate that the serum is of value in the preparalytic stage. There has, however, been no opportunity to study alternate cases with and without the use of serum.

The Illinois State Department has cooperated from the beginning in collecting and distributing poliomyelitis convalescent serum and for the last two years has financed its preparation.

It has been found that pooled normal adult serum in sufficient dosage (20 cc. to 30 cc.) will protect children from measles or chicken pox almost or equally as efficiently as the respective convalescent serums in smaller doses (5 cc. to 10 cc.). Normal serum has always been obtained in any quantity desired from unemployed men.

Effect of Serum on Measles Cases

The protection the serum gives against measles is of two kinds. Either it prevents the disease or limits it to a mild, attenuated attack. If a sufficient amount of serum is injected during the first five or six days after exposure, the disease is prevented entirely in 70 to 90 per cent of the children having no previous history of measles. When given from the sixth to ninth day of exposure attenuation is more likely to occur than prevention. After the ninth day of exposure very little effect can be hoped for, but attenuation or even complete protection may occur. Our results in about 800 home exposed individuals, a more severe test than hospital or institutional exposures, have been 97 per cent prevention and attenuation with either convalescent measles or pooled adult normal serum given during the first nine days of exposure.

Since mortality is highest from measles in infants from six months to three years of age, and in undernourished or sickly children of any age, it is generally agreed that one should attempt to prevent the disease in these children completely.

The passive immunity from the serum lasts only 10 to 14 days, but sero-attenuated measles is generally conceded to confer an active immunity as strong and enduring as that from the fully developed disease. Therefore, it is considered advisable merely to attenuate the disease in healthy children older than three years, as the risk from complications is slight in the sero-attenuated form, and is more than counterbalanced by the permanent immunity which follows. In hospitals and children's institutions, however, it is of extreme importance to prevent the spread of

measles or of any infectious disease, even comparatively mild ones such as chicken pox and mumps. It has been found at two children's institutions in Chicago that repeated injections of convalescent or normal human serum every ten days will keep a ward open and free from measles or chicken pox, and these repeated injections have never caused any reactions or allergic phenomena. Although this entails a great deal of work these institutions consider that they have been well repaid for their effort. Unfortunately, measles convalescent serum is not as efficient therapeutically as prophylactically. On a number of occasions, however, the intravenous administration of 30 to 60 cc. of this serum has been followed by rapid amelioration of a severe attack of measles. The further trial of similar therapeutic doses is indicated.

It is even more necessary to reduce the amount of cross infection in infectious disease hospitals. This also can be achieved by a liberal supply and use of the serums discussed.

Scarlet fever is a justly dreaded disease with an average mortality in this country of from 1 to 2 per cent. In addition many who recover bear the marks of cardiac, renal or other injury the rest of their lives. While not as infectious as measles, about 15 per cent of the children exposed at home to another child with scarlet fever develop the disease. With scarlet fever every effort should be made to protect contacts from developing the disease and thereby also prevent the development of an epidemic. In over 800 instances of home contacts given prophylactic injections of from 10 to 20 cc. of convalescent scarlet fever serum less than 3 per cent developed the disease, and of eighty-five institutionalized, Dick positive children, similarly treated, only 5 per cent developed scarlet fever.

Of Therapeutic Value Also

This convalescent serum has additional value as a therapeutic agent, especially if given intravenously early in the course of the infection. A few general results only can be given. The doses should range from 20 cc. for infants to 100 cc. for large adolescents or adults. A single intravenous dose given early was followed by an average fall of temperature of 2.5° in twenty-four hours and 3° in forty-eight hours, usually with the disappearance of toxemia and its manifestations, in over 800 severely ill, hospitalized patients.

Practically all complications were reduced by one-half or more, as compared with complications in 6,000 mildly or moderately ill patients, in the same hospital at the same time, who received the same general treatment but no convalescent scarlet fever serum. For example, nephritis developed in 3.5 per cent of the milder group not treated with convalescent serum, in 0.7 per cent of the severely ill group receiving serum, and in only 0.2 per cent of another group of 800 scarlet fever patients treated with the serum at home. Mortality rate is also reduced. During the period 1932-34, the general scarlet fever mortality rate in Chicago was 1.57 per cent in 26,611 cases, while during this same interval in 773 patients treated with convalescent scarlet fever serum at home within the first three days of illness the mortality rate was 0.5 per cent.

The Critically Ill Benefit

It also has been shown that patients with severe complications, or who are critically ill and not received at the hospital till late, are often markedly benefited, and at times apparently cured by convalescent scarlet fever serum. Similarly it has been found that various types of severe infections with streptococcus hemolyticus, which are not scarlet fever, also yield many times to convalescent scarlet fever serum after all other measures have failed.

Transfusions with whole blood from individuals recently recovered from scarlet fever, so called immunotransfusions, have been used by some with considerable success in desperate cases of scarlet fever, and in severe hemolytic streptococcal infections. Since the field of usefulness of immunotransfusions of various types is increasing in importance, the center maintains a list of immune donors.

Mumps convalescent serum appears to have considerable value as a prophylactic agent and has a real therapeutic value in the complications, such as encephalitis, orchitis or oophoritis.

Whooping cough convalescent serum appears to be of value in prevention and treatment, but the experience is not large enough to express a more definite opinion.

The Deutsch Convalescent Serum Center was started with the services of one part-time physician, one full-time technician and one full-time laboratory helper. More assistants were added as the work increased so that now there are three part-time physicians, four full-time technicians, two secretaries, and two laboratory helpers.

The first year (1931), 100 liters of blood was collected from 600 donors to prepare all types of serum, yielding 40 liters of serum. In 1934, 285 liters of blood was collected from 1,060 donors, yielding 120 liters of different types of serum. Many donors returned for several bleedings.

The total number of 5 cc., 7.5 cc., 10 cc. and 20

cc. vials distributed in 1931 was 1,500 and in 1934 was 6,400.

In all between 10,000 and 12,000 individuals have received prophylactic or therapeutic injections of convalescent serum. Since intravenous administration gives the best and most rapid therapeutic result, many patients received one or more intravenous injections of from 20 cc. to 100 cc. of convalescent serum. In this entire series there has been only one severe reaction, that in an adult with a severe pneumonia, who, however, seemed benefited by the serum and promptly recovered. Besides this there have been only a very few instances of mild urticaria, or a temperature rise of from one-half to one degree. The evidence shows, therefore, that convalescent serum, carefully prepared, is entirely devoid of danger whether given subcutaneously, intramuscularly or intravenously, providing it is properly warmed and is administered slowly with a syringe which has been sterilized by boiling in distilled water in a clean vessel.

Technique Is Important

We believe that the gentleness with which the blood is handled, the prevention of hemolysis and the drawing of blood not sooner than three hours after the donor's previous meal are of ultimate importance in making convalescent serum a safe therapeutic agent which will not cause reactions.

In 1933 about 200 physicians secured serum from the center and 450 in 1934.

There has been a regular demand and a steady supply of the following types of serum: convalescent scarlet fever, measles, chicken pox, erysipelas, poliomyelitis and mumps serums and pooled adult normal serum. The following serums have been given clinical trial or investigation: convalescent pneumonia, pertussis, epidemic encephalitis, and "common cold" serums.

The center became self-sustaining after two years of operation. This has been made possible by the sale of serum to private patients through their physicians and to some hospitals and institutions at the rate of $5 for 20 cc. of serum.

Whereas this increase in the use of convalescent serum indicates that physicians and patients have recognized its value, a greatly increased use, especially for prophylaxis, is needed genuinely and safely to control and even prevent epidemics of such diseases as scarlet fever and measles, and perhaps of some others. This expansion will be possible only when public health agencies, city, state or national, actively undertake both the service and investigative functions in this field.

It is necessary that convalescent serum centers be placed in large cities where the source of the serums, that is, the number of recovered patients, is greatest and where these donors are not too scattered, so as to make collection simple and economical. However, workers in the center can go from 100 to 200 miles to smaller cities, camps and institutions where infectious diseases are prevalent, secure blood from those who have recovered, process it at the center and return whatever serum is needed to the source furnishing it. The Deutsch Center has done this to some extent.

Milwaukee Center Established in 1934

During the 1934 scarlet fever epidemic in Milwaukee a request came to me to undertake the establishment of a similar convalescent serum center in that city. Convalescent scarlet fever serum had been furnished for the treatment of the fourteen-year-old son of a prominent Milwaukean. The boy had been ill for twenty-four hours, his temperature was 104° and he was very toxic. Seven hours after 60 cc. of serum had been administered intravenously, the child's temperature fell to normal, the toxemia and rash completely disappeared and his convalescence was rapid and uneventful. In appreciation of this result the grateful father offered to finance the Milwaukee Convalescent Serum Center at Columbia Hospital and asked me to organize it. This task was accomplished in approximately 30 days.

The value of at least several convalescent serums in preventing and treating their respective infectious diseases seems to have been proved conclusively. For a number of other similar diseases a fair amount of evidence more than suggests the therapeutic or prophylactic value of their respective convalescent serums. There are other infectious diseases for which it is logical to believe that convalescent serums will be of value.

Many investigators who have had excellent results with convalescent measles serum and with normal adult pooled serum have felt that an inadequacy of supply of these serums was all that prevented their general use. It has now been demonstrated that a large supply of many convalescent serums can be obtained and maintained. In order to do this all that is necessary are centers to carry out this work, trained personnel, moderate funds and the cooperation of public health agencies on a state or even a national basis. The public benefit would be not only a marked reduction in the incidence of infectious diseases and their accompanying morbidity and mortality, but also an economic saving to private families and public hospitals, which would far exceed the moderate cost of establishing and maintaining the serum centers on a scale adequate to meet the needs.

Topping Dayton's Bluffs, St. John's looks down on St. Paul and its environs but is remote from the city's smoke and noise. On the left of the picture appears the nurses' home which was the hospital's first home.

St. John's Is Meeting Its Problems Squarely

By RAYMOND P. SLOAN
Associate Editor, The MODERN HOSPITAL

"EVERY private room filled — every bed taken, with the exception of two in the maternity division."

An interesting introduction to any hospital in these times, but particularly to a modest little institution of seventy-five beds and fifteen bassinets located on the outskirts of a metropolitan center which boasts far more elaborate accommodations.

For a little hospital, St. John's of St. Paul, Minn., has a surprising air of importance about it. Topping Dayton's Bluffs, it faces squarely the world in general, and the entire city of St. Paul in particular. Of the city, yet apart from it, it looks down upon the smoke and haze of countless puffing chimneys, at the same time remaining curiously remote from any contamination caused by polluted atmosphere. Boldly inscribed across the steep embankment which leads to its front door are the words "St. John's Hospital" in large letters patterned of stones painted white. Indelibly is the name printed on the landscape, as it is upon the minds and hearts of the entire community.

Facing every situation squarely has become a habit acquired by St. John's during the twenty-four years of its existence. Necessity demanded it. Financial pressure imposed rigid limitations which only the closest supervision could hope to meet. The hospital has never failed to pay its bills promptly, nevertheless, and is steadily liquidating the indebtedness incurred by building operations in 1915. Too, it enjoys the distinction of ending up each year with a modest balance.

St. John's finds itself in the unique position of having a church affiliation, but not in the usually accepted sense of the term which implies church support. It was originally established as a hospital under Lutheran control sponsored by a benevolent society comprising members representing the various Lutheran churches of the synodical conference. When larger quarters became necessary in 1914, the benevolent organization was converted into a stock company and sold

shares in the Northwestern Lutheran Hospital Association.

The governing board comprises fourteen trustees who meet regularly each month with the medical director and the superintendent. They are appointed for a term of two years by the congregations comprising the synodical conference, those individuals holding stock in the hospital being eligible to cast votes. The entire issue of common stock is held by the Northwestern Lutheran Organization, but the preferred stock has been made available to outsiders. Dr. F. J. Plondke has been medical director since the hospital started in 1911.

It was only through such an arrangement that the necessary building operations were completed. The hospital has no endowment, receives no outside aid, and solicits no financial help. It is entirely self-supporting, even to the point of paying off its capital debt. While still governed largely by Lutheran interests, the church assumes no financial obligation for its activities. It cannot ever be said to have a particularly active women's auxiliary. This group meets four times a year.

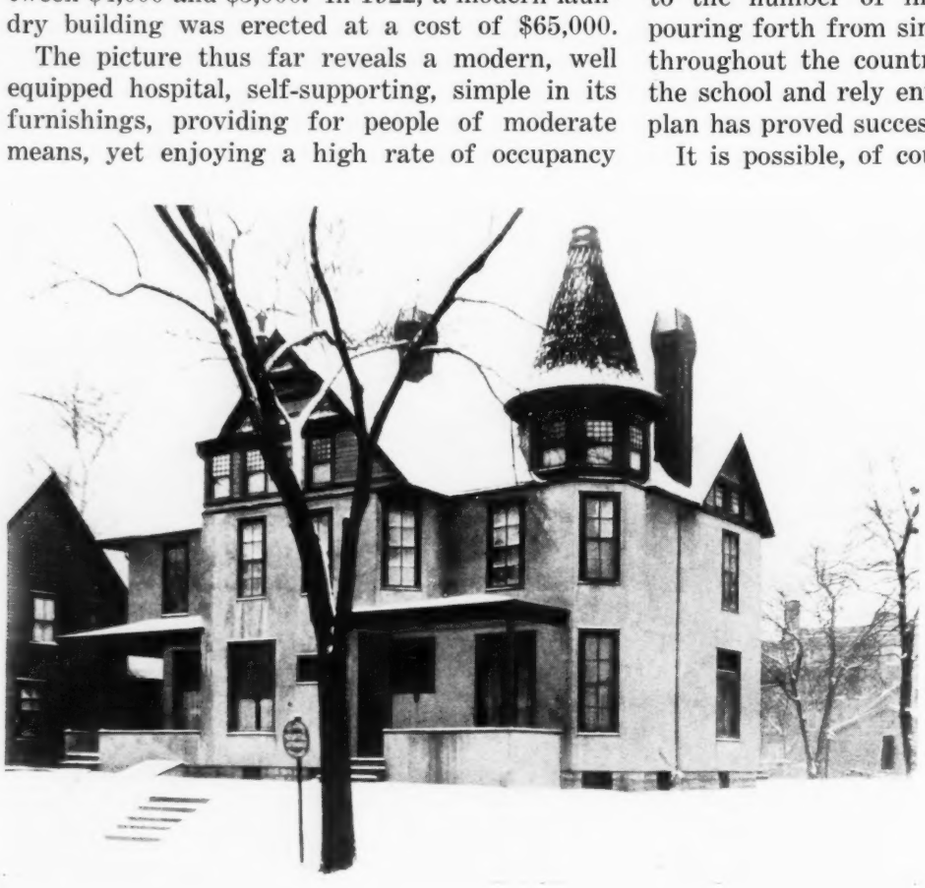
Approximately $125,000 was spent on the present hospital building erected in 1915. The old building was then transformed into a nurses' home at a cost of $2,500 and another structure was added for a maids' home representing between $4,000 and $5,000. In 1922, a modern laundry building was erected at a cost of $65,000.

The picture thus far reveals a modern, well equipped hospital, self-supporting, simple in its furnishings, providing for people of moderate means, yet enjoying a high rate of occupancy which has steadily increased during recent months to the point of actual capacity. To this should be added a medical and surgical staff of between fifty and sixty comprising both visiting and regular physicians. The only requisite is that the individual be a member in good standing of the Ramsey County Society. There is a resident full-time physician and a junior medical student.

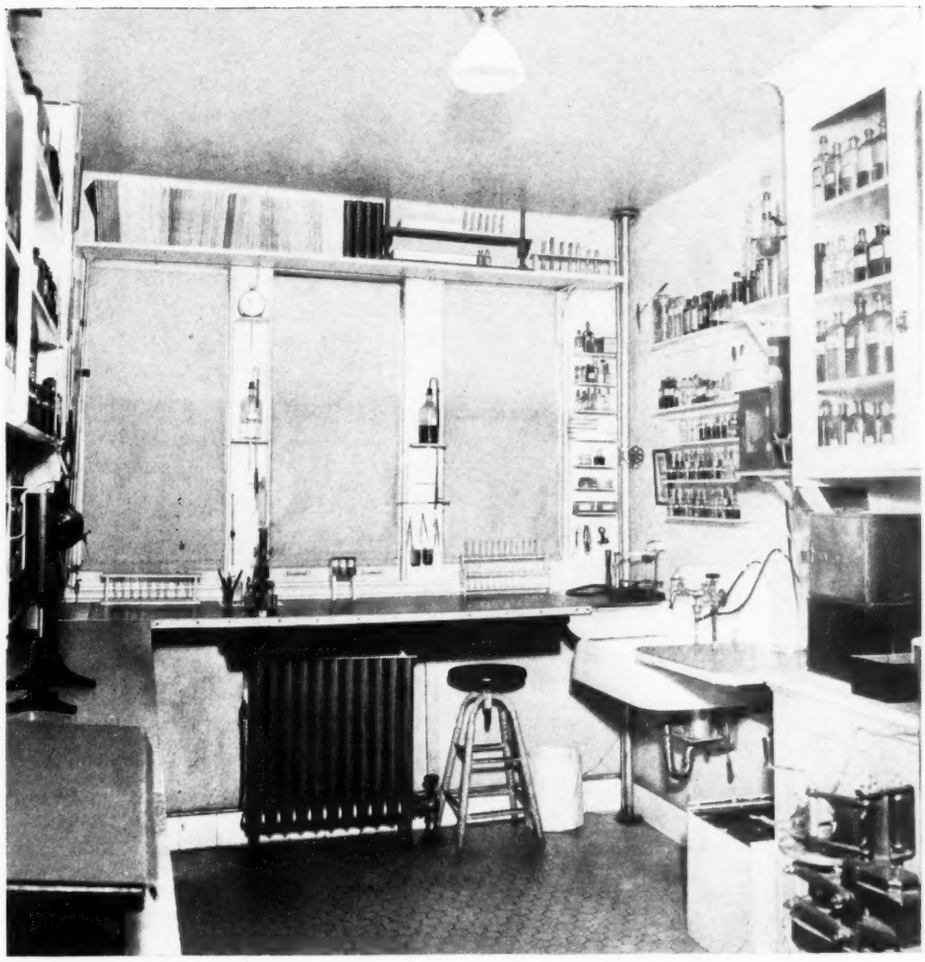
It is now interesting to look a bit further. It would not be surprising, were he to pay the hospital a particularly early morning call, for the visitor to discover an automobile, Dodge by name, approaching the rear entrance laden with vegetables and other perishable foodstuffs. It serves as an ideal introduction to Magdalena M. Rau, superintendent, who has filled the executive post since the hospital first was started. Miss Rau is largely responsible for the fact that existing conditions have always been faced squarely. Just one reason why ever so often in company with her dietitian she visits near-by markets and stocks up enough vegetables and potatoes to last for one or two weeks. Better foodstuffs is the result.

The same direct method of approach is exemplified in meeting the nursing situation. The hospital started with a training school. In 1932 it became evident that some change would have to be made. Proper instruction entailed expenses which could not be met. Rather than contribute to the number of inadequately trained nurses pouring forth from similar small training schools throughout the country, it was decided to close the school and rely entirely upon graduates. The plan has proved successful.

It is possible, of course, that impending problems will ultimately disrupt the present satisfactory set-up. With increasing demands for private nurses and the extension of social service work, the hospital may one day be obliged to pay more for the services of graduates than it can afford, making necessary a return to the training school. But that is some-



The home for the maids is also used by the engineer and his family. It was built in 1915 and cost over $4,000.



The laboratory is well equipped. The workers include a part-time pathologist and a part-time roentgenologist.

thing which only the future can determine. It is mentioned merely to illustrate the disposition of those in charge to be mindful of possible contingencies.

Results recorded at St. John's could never have been achieved without the cooperation of the entire personnel. The feeling has been engendered throughout the organization that each one must do a bit more than his own particular job, and always be ready to assist in emergencies. So whole-heartedly has the personnel subscribed to this idea, that despite a pay cut applied to salaries which even in normal times were not too high, and the elimination of all vacations with pay, the turnover has been negligible.

Between sixty-five and seventy employees are on the pay roll. The personnel chart breaks down as follows: first, the superintendent, who is responsible for the efficient conduct of the entire organization, and also serves as superintendent of nurses. With the exception of foodstuffs, which are left solely to the dietitian, Miss Rau does all the buying, although upon occasion, as already noted, she may make an excursion to the neighboring markets. In addition, she contacts personally each patient every day, and in the event of serious illness twice a day. Despite the presence of a trained anesthetist, also an assistant, Miss Rau is qualified to assume the rôle if an emergency arises.

A modern laundry building was erected in 1922 at a cost of $65,000. It connects with the nurses' home.

The assistant superintendent serves as historian and assistant anesthetist. The anesthetist, in addition to her own individual work, helps in the operating room, where she is in charge of gloves and other supplies. There is also an operating room supervisor and three graduate nurses.

One ward maid divides her time between the laboratory, the operating room, and the fourth floor which comprises the obstetric department. Three graduate nurses are employed in the obstetric department and the supervisor divides her time between this department and the third floor which is devoted to surgery. Five graduate nurses are on this floor with the services of one ward maid. On the second floor are five graduate nurses and two ward maids. One supervisor is in charge of the first and second floors. On the first floor are four graduate nurses and one floor maid. The night nurses include one night supervisor, four graduate general duty nurses and two graduate general duty nurses, called "floaters," who give assistance wherever it is needed.

It should be explained that there are thirty-

five private rooms in all; two wards with five beds; six wards with three beds and five wards or semi-private rooms with two beds. Private room charges range from $4 to $5.50 and the ward rates are $3.

The dietitian is in complete charge of the kitchen department and also serves as housekeeper. This arrangement was made possible due to the discontinuance of the training school which relieved the dietitian of certain duties. One cook is employed and an assistant. A maid takes care of special diets. In addition there are two dining room girls.

Another instance of facing problems squarely is revealed in this department. It was found that by introducing cafeteria service at the dinner hour, less help would be required, this being the meal when the greatest amount of food is served. So cafeteria service has been instituted, employees merely taking their plates from the steam table and walking to the dining room. At breakfast and supper, so called "family" service is in effect, that is, the food is placed on the table and each one helps himself.

The layout of the hospital is such that central tray service is impossible. Food is sent upstairs on dumb-waiters and served by maids from diet kitchens on each floor. All dishes are washed in the diet kitchens; while not conducive to quiet, this is necessary under the existing plan.

Each day the dietitian makes personal contacts with the patients, soliciting their preference for one type of food as against another, and catering to their individual tastes when it is possible to do so. In conjunction with the bookkeeping depart-

NAME Martin Jones No 14447 A

PATIENT'S REQUISITION

Form 65 50M 5-35 B P

QUANTITY	DETAIL	COST PRICE	SELLING PRICE
1	Bath Tray	10	15
1	- Morph Sulph gr ¼	02	10
	TOTAL		

DOCTOR Briggs DATE 10/10/35

ROOM NO. 9 11 DEPT.

NURSE M Roehl OK'D BY E. Rehm

A sample of the requisition blank for patients' supplies.

ment which checks on the figures, an accurate record is kept of food costs. For example, at present, food costs, including salaries, gas, electricity, average about 25 cents per meal. Raw food costs average about 15½ cents.

The dietitian, as already indicated, likewise serves as housekeeper. In addition to the maids coming under her supervision, there are also two janitors who clean windows and rugs and take care of the back entrance. The engineer and assistant, the fireman and the lawn man are directly responsible to the superintendent. The laundry department is responsible to the superintendent.

In the office department is a bookkeeper, an assistant and a girl clerk, who also serves as telephone operator. The laundry requires the services of one man and four girls, one of whom serves as forelady. Incidentally, the laundry is termed a "paying" department.

In the laboratory is a part-time pathologist and a part-time roentgenologist. Two technicians do both x-ray and laboratory work, alternating between the two. The hospital is particularly fortunate in its arrangements for these part-time services through affiliations with other institutions in St. Paul.

Central Supply Room Controls All Supplies

What has contributed more perhaps to the general efficient operation of St. John's than any other one plan is its central supply room. This controls all supplies, linens and other materials. One graduate nurse is in charge, assisted by the part-time services of another. This room is open from seven in the morning until seven at night.

One requisition blank answers all requirements. This form applies to items for patients as well as to miscellaneous household supplies. It provides ample room for recording the quantity, description of the article, its cost price and the selling price. The doctor's name is included, the patient's room number, the name of the nurse and the signature of the individual who O. K.'s the requisition. All very simple, yet entirely adequate for the purpose.

Particularly significant is this form in that it represents merely a beginning of business methods as applied to the bookkeeping department. Much more remains to be accomplished along this same line, but it is necessary to adhere to the rule of one thing at a time.

Much more remains to be done as a matter of fact along numerous other lines. Nothing would be more pleasing to everyone associated with St. John's, for example, than being granted the privilege of applying generous coatings of paint and varnish here and there. And better accommodations would make the admitting procedure far simpler.

"Such things will come," is Miss Rau's firm conviction. "In the meantime, we are meeting our bills." She speaks with quiet confidence in the knowledge that with increasing occupancy will come proportionate institutional advancement.

Prescribing Books for the Tuberculous

By GERALD B. WEBB, M.D.
Colorado Springs, Colo.

Our remedies oft in ourselves do lie
Which we ascribe to Heaven.
—Shakespeare.

A DIAGNOSIS of tuberculosis produces a psychic shock. Only those who have experienced such a verdict know the horror. Young adults form the majority of such patients, and with blasted hopes and faced with what seems like a death sentence few of them realize what is demanded of the spirit. A brave man can face the momentary danger of "going over the top," but the same individual may not be able to endure the long rest regimen which is necessary to overcome this disease.

The treatment of tuberculosis calls for resourcefulness that is unequalled in any other specialty. The physician has the double task of administering to both mind and body and manifestly this cannot be done merely by peddling pills. The radio has been a godsend to tuberculous patients, mitigating many weary hours, yet the mind still needs the sustenance that can be procured only by the proper prescription of books. One can read in the minds of these patients thoughts expressed by Scott:

I myself must mix with action
Lest I wither by despair.

and by Homer:

Too much rest itself becomes a pain.

In spite of the modern trend of collapse therapy the cure of tuberculosis, a chronic disease, is still long and tedious. The layman often has the notion that the proper treatment of the disease is a discovery of our own time; but Hippocrates, the father of Greek medicine, appreciated the value of rest. Avicenna, that Prince of Physicians of the Arabian renaissance — to whom some Persian historians attribute the Rubaiyat — stressed the resting of the body and of the mind.

Books Relieve Mental Unrest

Their advice is as good today as it ever was. No doubt both Avicenna and Hippocrates, however, found their patients as loath to take their advice as we do today. No doubt, too, they found many a patient who achieved rest of body without attaining rest of mind. This mental unrest is something that the tuberculosis specialist must meet and conquer throughout all the days of his practice. Books form the greatest weapon against it in his armory; judicious reading is the first antidote to mental unrest. Dryden wrote long ago, with his customary perspicacity:

Lack of occupation is not rest
A mind unoccupied is a mind distressed.

In Dryden, as in the other authors just quoted, there may have been something of the psychiatrist. If we knew more about the physical ailments of such men, however, we might be better able to explain such flashes of insight as these. In the ancient Vedic hymns of India one reads that only the man who is master of himself can recover from consumption. It has long been a maxim with physicians that no fool ever recovers.

Nature Books Recommended

Some patients must be kept resting in bed from four to six years before they recover. The problem of keeping up morale and courage can be met only by the selection of proper literature. Were you to ask what literature proved the most satisfying and helpful I should unhesitatingly reply books relating to the study of nature.

You will note in reading "Experiment in Autobiography" by H. G. Wells that biology is placed first in education. Wells' own success as a littérateur resulted from an early training in natural history. It was this knowledge that gave Wells such deep insight into human relations. Like so many famous authors, such as Voltaire, Ruskin, Emerson, Keats, Shelley, Pope, Stevenson and many others, Wells himself was a consumptive. His triumph over this disease and his subsequent strenuous life should inspire others. Included in descriptions of Wells' literary friends is that of Stephen Crane, one of the unfortunate victims, like the Brontës, who gave us his immortal "Red Badge of Courage," a book too little read today.

The best approach I know to the enjoyment of nature is the selection of books like Fabre's on insects and on astronomy, and such works as "Flashlights on Nature" by Grant Allen, "Bird Watching" by Edmund Selous and such simple instruction as that given in "Eyes and No Eyes" by Arabella Buckley.

Few instructors can make nature interesting.

It does not interest people to know the classification of plants or how many sepals and petals a flower may have. But if patients are told that our beautiful painter's brush puts on its gay clothes at the expense of its honor they are at once interested. They have perhaps met with similar human beings! A flower cannot live without green leaves. The painter's brush turns many of its leaves into the gorgeous red bracts and in order to do this sends out "suckers," which steal nourishment from all roots growing around it. Show patients the sensitive stamens of the common barberry and how they snap towards the pistil when gently touched with a pin, and interest is at once aroused. Should kind friends send in begonias or lilies of the valley, show them the male and female flowers on the stem of the former, which they have never noted, and tell them that the flowers of the latter if left undisturbed in the garden turn into beautiful red berries in the fall — a fact known to the birds but to few florists.

Nature study will give the patient a better understanding of his own disease and will make him realize that a parasite like the tubercle bacillus must look out for its own progeny. Such a parasite has developed, over the ages, access to the human and egress from the host. It must constantly develop new colonies; otherwise the race of bacilli would become extinct. Ulceration of the lungs, with germ containing sputum as the result, is the aim of this bacillus. It has no life history outside the human body and the dissemination of the germ by the consumptive is especially dangerous to children.

Helpful Literature From T. B. Association

The National Tuberculosis Association issues excellent literature concerning this disease. Among this is a pamphlet entitled "What You Should Know About Tuberculosis," and the *Journal of the Outdoor Life*. Numerous books have been published for patients such as "Rules for Recovery" by Lawrason Brown, "Tuberculosis" by Fred G. Holmes, and "Overcoming Tuberculosis" by Webb and Ryder.

Experience has shown that most patients tangle themselves up in dangerous "little knowledge" and, being without a proper educational background, find such reading depressing. They cannot grasp the difficult facts and are at sea in regard to the simple ones. Patients become appalled at the wicked possibilities of the treacherous foe. Possibly many of these books in attempting to radiate hope are tinged with too much optimism and do not stress sufficiently the relapsing nature of the disease. The two most important facts to be emphasized are that rest is the only real remedy and four years of careful medical supervision are absolutely necessary for recovery.

Many among my audience have written me delightful letters commending my publication "The Prescription of Literature." It may be of interest to you to learn how that work originated. Some thirty years ago I had a patient with so-called neurasthenia. I discovered that the probable reason that no progress was being made in treatment resulted from the fact that she had a standing order with the book shop to send her every new novel. One of my hobbies has been the reading of biographies and from the trials and triumphs of the subjects I have derived great inspiration. I quickly discovered that with this patient, as with others, biographical reading, a variant of nature study, accelerated recovery.

Discover Patient's Interest

From that time it has been my custom to look around my library each morning and emerge with an armful of books. The varied interests of patients are soon discovered and appropriate books can be taken to them. "The Prescription of Literature" was therefore the work of a lifetime and any further contribution to this theme is in the nature of an anticlimax. An attempt was made to put forth all the ideas that could be gathered on appropriate reading for the sick. The greater number of such patients were tuberculous and it was discovered that —

> Whether they take Cervantes' serious air
> Or laugh and shake in Rabelais' easy chair,

the reading of biographies was prolific in good results.

Nevertheless there are one or two additions or amplifications which I may make at this time. In view of the old adage, "A little nonsense now and then is relished by the best of men," it may be that such reading was not sufficiently stressed in "The Prescription of Literature." Certainly the physician must not forget to prescribe such works as "Fun in Bed" and "More Fun in Bed" by that cheerful invalid, Frank Scully. The difficulty in such matters is, of course, that so many humorous works lose their appeal in a few years because of changing conditions. Who reads Bill Nye or Edward Lear today? In the realm of humor, the physician must keep up to date. He may find that in another decade his patients will no longer react to Robert Benchley or Don Marquis or Captain Traprock.

Another footnote to "The Prescription of Literature" might consist of an account of a curious kind of literary quest in which I have encouraged some of my patients to engage. It is a search for symptoms resembling their own in the writings

and biographies of great men. Although Eugene O'Neill has commented upon this tendency among patients as a kind of weakness, I know it can be turned to good account. I have elsewhere related how one young lady detected correctly from some of Shelley's lines that the poet must have suffered from tuberculosis, and how another discovered from Carlyle's "John Sterling" that this poet had also been a victim. It can also be recognized that this disease not only influenced the writings of authors but also their lives.

A Sidelight on Shakespeare

It will interest both librarians and tuberculous patients to learn how the works of Shakespeare can be analyzed to indicate the possibility that this great poet may also have been tuberculous. Little is known of Shakespeare's life but his biographers believe he died, April 23, 1616, in a fever. Shakespeare has many references in his plays and sonnets to such conditions as "fistula," "kings' evil" (scrofula or tuberculous adenitis), "infected lungs," and "consumption." A patient interested in Shakespeare kindly marked these for me. The poet appeared to know also that consumption was curable, for Beatrice in "Much Ado About Nothing," (1599) in accepting Benedick, says "I would not deny you; . . . and partly to save your life, for I was told you were in a consumption."

In 1611 came "The Tempest" and from this date to the time of his death no more plays were written. In January, 1616, a will is being prepared. It is important to search in Shakespeare's last play "The Tempest" for any suggestion of illness, and the epilogue seems to indicate we shall not be disappointed. We read:

> Now my charms are all o'erthrown,
> And what strength I have's my own
> Which is most faint. . . .

Here is found the suggestion of malaise or lassitude so common in a toxic consumptive. The following conversation indicates a knowledge of the consumptive odor:

> Adrian: The air breathes upon us here most sweetly.
> Sebastian: As if it had lungs and rotten ones.
> Antonio: Or as 'twere perfumed by a fen.

But the most important lines indicate the experience of a symptom for in eight words is penned, in "The Tempest," an unsurpassed description of pleurisy. Prospero retorts to Caliban that he will suffer that night "side-stitches that shall pen thy breath up." It would seem to a physician that only one who had suffered from pleurisy could have written such an apt description. The finding of these subjective and objective symptoms all collected in his last play together with his cessation of work for five years before his death, arouses a suspicion, that, like Molière who died at fifty-one from tuberculosis, Shakespeare's life was perhaps terminated by this relentless foe at fifty-two.

Interesting books abound for every occupation and the opportunity is offered one taking the tuberculosis cure later on to outstrip his fellows in life's handicap. While those who will be his competitors are rushing hither and yon, he is learning to conserve his energy and to concentrate on matters that will count. Many have won success as business and professional men, who have had what seemed to be enforced idleness for several years.

In singling out one occupation, a physician in this work always has numerous medical students and young doctors under his care. Medicine is actually a branch of nature study so that all branches of natural history will be pursued with interest. Apart from general biography there are available many biographies of famous physicians that will prove of valuable interest. For these patients and for other intellectuals, medical history should be emphasized. Knowledge of what has gone before in medicine will save them numerous future mistakes and will encourage an interest in research. Magazines like the *Annals of Medical History, Aesculape* and *Janus* form an approach to the subject. Numerous books like Garrison's "History of Medicine," Sigorist's "The Great Doctors," McKenzie's "The Infancy of Medicine," the Clio Medica series, Singer's "A Short History of Medicine," and many others make excellent reading. Biographies of great physicians, like Laënnec, Harvey, Osler, Thomas Young and Allbutt, are full of inspiration as well as those of scientists like Pasteur.

Making Scrap Books

Patients have studied pursuits from candy making to clothes pressing and the making of jig-saw puzzles, to emerge into successful businesses. The clipping of paragraphs and pictures during fever periods, which have later been pasted into scrap books, gives unending joy and information. Some of these from "Architecture" to "How to Amuse Children on a Rainy Day" made by patients more than thirty years ago, have often been borrowed for the advantage of more recent patients. Memorizing of paragraphs and poems is excellent diversion and leads to concentration. From Gilbert's "Bab Ballads" to Thackeray's "Ballad of Bouilla-Baisse" patients will be able to recite and recall lines that make them admired in cultured society.

In general the advice given by Bulwer-Lytton is still appropriate: "In science, read, by preference, the newest works; in literature the oldest. Classic literature is always modern."[1]

[1]Read at the meeting of the American Library Association, Denver.

Someone Has Asked—

How Can Hospital Noise Be Reduced?

Instead of being havens of quiet and orderliness, many hospitals from daylight to dark are places of noise and confusion. This state of affairs can not be excused. The hospital executive can do much to prevent the annoyance of patients by reverberating voices of nurses, doctors and visitors.

Members of the hospital personnel should be schooled to walk lightly and talk softly. Properly placed electric "silence" signs have been found useful. The quieting of squeaking trucks and stretchers, and the silencing of slamming doors are practical measures.

The members of a hospital personnel cannot accomplish the expected quietude without assistance from the superintendent. Unless aid in controlling physical causes of noise is given, nurses and others will become discouraged and fail to play their personal part in the campaign.

A correction of this difficulty cannot be brought about without continued effort on the part of each department head. Radios, unless properly controlled, become a part of this conglomerate nuisance. Patients who are annoyed should register righteous indignation. Quietude and orderliness can be secured if intelligent effort is directed to this end.

Should a Surgeon Be Allowed to Alter Visiting Rules?

In a hospital that does not permit visitors except at stated hours and does not allow children to visit at any time, the chief of the medical staff sometimes tries to secure visiting privileges for the relatives of his patients at hours other than those covered by the rules. He insists that since he refers so many patients to the private department he has the right to accommodate his clientele even though he breaks the institution's visiting rules. The answer to this question is obvious to most administrators.

A member of the staff who is inclined to assume authority not delegated to him should be tactfully but firmly curbed by the hospital superintendent. It is not necessary in so doing to create any personal animosity. It is regrettable that sometimes unless staff physicians have their own way they develop a persecution complex. No rule which has been approved by the board of trustees may be broken by anyone but its representative, the superintendent, except in the case of the greatest emergency.

The staff has no authority to alter visiting rules. The superintendent who permits this to be done is simply postponing a day of reckoning. A tactful firmness on the part of the executive will usually control the situation.

Should a Superintendent of Nurses Consume Alcoholics Before Her Subordinates?

In this age of vaunted personal freedom there are those who would calmly answer this question in the affirmative. There are others, among them the superintendent of the hospital who submits this query, who will not allow a directress of nurses to continue in her position if she repeats this practice.

The superintendent of nurses should exemplify the highest degree of decorum and tact. She should set the example both personally and professionally for every member of the department of nursing. If it is necessary for her to be staid and Puritanical as the world understands these terms for the good of her school, then she should curb her own personal inclinations to be just that. She certainly should not drink or smoke in the presence of her pupil nurses.

The executive of the hospital who demands either a resignation or a reform from his directress who thus offends is justified in his stand.

Should the Physician Be a Member of the Board?

There is a somewhat militant demand on the part of physicians generally that they be represented on the governing body of the hospital. It is contended that since the doctor sends the hospital its paying patients, he should have a voice in the physical conduct of the institution. There is little to commend such a policy. The average physician is too much concerned in the medical care of his patients to give much thought to the physical and administrative angles of institutional work. He is more likely to see defects than to give advice as to their correction.

It is true that the hospital's income is secured largely through the physician. On the other hand, the hospital furnishes, at great expense, the implements with which the physician works. It is said that the presence of a physician on the hospital board of trustees provides medical advice when necessary and prevents errors on the part of the governing body. Theoretically this is true. But this advice can be supplied by an executive committee of physicians or by a joint conference committee composed of members of the visiting staff and of the board of trustees. It would give rise to complications for a board member to sit at staff meetings and there are disadvantages in having a staff member present at deliberations of the board.

Little is to be gained by the adoption of such a policy intended only to recognize the importance of the medical staff to the hospital. The average physician is not interested in discussions on investment of hospital funds or on improvements to the lawn or the buildings. The presence of a physician on the hospital board has proved beneficial in some institutions. On the other hand, a practical and understanding relationship between the doctor and the board of trustees has been brought about by the presence of a joint board and staff committee or by an advisory committee of physicians working with the board of trustees.

Should Operating Room Charge Be Raised When a Patient Needs Two Operations?

This question is asked by the superintendent of a Western hospital in which an objection was raised to a rate card which provides for a charge of a fee and a half when more than one major operation is performed at the same time on the same patient.

This executive contends that more supplies are necessary and that the time consumed by the operating room staff is greater when multiple major operations are performed, statements which no doubt are true. On the other hand, hospital executives should be cautioned against increasing service fees without a good reason for the higher rate. The patient must not be given the impression that the hospital is taking advantage of his physical incapacity to demand a payment at every turn for some service which would seem to be inescapable on his part.

No matter how many operations are

performed on the same person at the same time a flat operating fee only should be exacted. After all, the law of averages will compensate for the increase of surgery in the case of one as against a minimum amount in the instance of another. The more the hospital can approach a flat fee basis the less opportunity for complaint will be given the patient.

Who Should Notify Relatives of a Patient's Death?

Hospitals are too often thoughtless, if not actually cruel, in the methods they adopt in notifying relatives of the fact that a patient has expired. Sometimes a tactless or hurried information clerk simply and without prelude states that a loved one has died. Again a message may be transmitted through the police department. Too often a family is awakened in the small hours of the morning to receive this information when to await the coming of daylight would have been tactful and would have served the same purpose.

To request that a relative come to the hospital because of the critical illness of a patient who had in reality expired and then humanely to lead up to the real situation is a kind way of imparting such dire news. Whatever method is adopted, it should be humane and tactful and this unpleasant, though very necessary, duty should not be routinely left to a low salaried and unskilled clerk or other employee. The intern is often the logical person to transmit this information and he is usually capable of representing the hospital in rendering this service.

How Should the Staff Approach the Board of Trustees?

There is a strong feeling in some hospitals among the members of the visiting staff that their opinions are not valued by the board of trustees and that they have no easy avenue of approach to the governing body of the hospital.

This, in some instances, is all too true. A great administrative gap separates too often the staff and the board. To be sure, a medical executive officer is usually capable of furnishing specialty advice to the board and yet, in a way, this does not suffice. The staff of today has more or less with reason assumed that its activities are vital to the hospital because it refers paying patients to the hospital's private department. It more than ever is demanding its place in the administrative sun.

Now, the conduct of the hospital cannot be delegated to the staff. On the other hand, the board should respectfully listen to its suggestions and should act favorably on those which seem in the best interest of the hospital. A conference committee consisting of members of the board and staff is probably the best method of meeting these staff demands. Often when this avenue of approach is created the staff finds that after all the conduct of the hospital rather nearly meets with its approval.

To the person asking this question The MODERN HOSPITAL suggests that the creation of a conference committee will tend toward improving staff morale by creating an assurance that the board is interested in what the staff is doing and that it really appreciates constructive administrative criticism.

How Should the Superintendent Address His Subordinates?

A visiting executive in a recent inspection of a general hospital was somewhat startled to observe that the superintendent was inclined to adopt a rather frivolous and playful attitude with floor supervisors, department heads and even pupil nurses who were encountered on tour. This attitude on the part of the superintendent appeared perfectly natural yet the visitor found it difficult to reconcile this practice with his preconceived ideas of professional dignity.

It is a time-tried axiom that the formation of close friendships among the members of the hospital personnel is not to be encouraged. This is particularly true when relationships between superior and subordinate are considered. Discipline suffers when a previous social friendship or over-hearty congeniality has existed, and a reprimand is deserved by the subordinate.

The executive does not need continually to present a dour countenance, but he should figuratively place himself in a position definitely removed from his subordinates. There is nothing which generates respect more certainly than refined, dignified behavior, and few factors break down professional respect to a greater degree than continuous frivolity and familiarity.

When May the Doctor Refer Clinic Cases to His Office?

It is natural that a dispensary patient should learn to respect the ability of some particular dispensary doctor and covet an opportunity to secure his sole attention.

Requesting the physician's name and the location of his office, the patient asks if he may make a visit. The doctor is then in a dilemma where, ethically, he must refer his patient to the director of the clinic or the social service department for this information. A physician who solicits private patients in the dispensary is unethical, and should be punished by dismissal from the staff.

For the social service department to admit patients who are able to pay for a private doctor is wrong and represents inefficiency. Circumstances may arise, however, which would seem to be extenuating insofar as the physician is concerned and these should be taken into consideration.

To Whom Is the Nurse Answerable?

The answer lies in considering the administrative set-up of the hospital.

The board of trustees is totally responsible for every activity in the institution. The superintendent answers to the board. The directress of nurses answers to the superintendent. All pupil and graduate nurses working in the hospital are responsible to the superintendent of nurses. These statements are made from a purely administrative angle. The nurse is responsible to the physician for the care which she gives to his patient.

In the last analysis it is the directress of nurses who bears this responsibility. The superintendent of the hospital insists that the directress of nurses provide such care for patients as the physician orders. In cases of emergency and in fact in actual practice physicians give orders directly to the pupil nurse. Routine orders appearing on the chart are in reality instructions to the directress of nurses to see that her subordinates provide the care requested. If these basic administrative facts are thoroughly understood no friction or misunderstanding should arise.

If you have any questions to ask, the Editor will be glad to discuss them in a forthcoming issue

What Others Are Doing

Hospital Sketches Used to Aid Financial Campaigns

Using material furnished by the eighteen hospitals included in the Welfare Federation of Philadelphia, the Hospital Association of Pennsylvania, as a part of its educational program, has prepared a series of instructive sketches pertaining to different departments of hospitals in which it was thought the public would be interested.

These have been distributed to more than forty community chests and welfare federations throughout the state for use in their fund raising campaigns, with instructions on how to adapt the material to different sized hospitals. The Welfare Federation of Philadelphia is using the series as a handbook for its speakers and publicity staff.

As an illustration of the type of material used in the sketches, the article on the dietary department tells the story of "A 4-Ton Meal." The boiler room sketch explains why the eighteen hospitals must produce power equivalent to furnishing a city of 56,250 with water, electricity and heat. The laundry story touches upon the 150-ton weekly wash, and the sketch on supplies talks in terms of 1,900 miles of bandages, and 390 miles of adhesive plaster.

Extra Telephone Service Has a Double Value

The General Hospital of Syracuse, Syracuse, N. Y., is offering its staff and associated physicians a twenty-four-hour telephone contact service at a nominal monthly fee.

Under the physician's listing in the telephone book is a line "If no answer call 2-1451" (the hospital switchboard). When the physician leaves his office or home he calls the hospital operator and tells her where he can be reached in the event that the hospital receives a call for him. If he is leaving town he gives the hospital the name of the doctor who will take care of his calls.

In describing this service Carl P. Wright, superintendent of the hospital says: "If the doctor fails to notify us of his whereabouts we know from experience where he might be found but if we cannot locate him, he knows that we will send one of his fellow staff members, capable of giving the patient such emergency service as may be required.

"While there are commercial agencies who are operating this type of service it is obvious that hospitals should be able to give an especially efficient service because they are working in closer contact with the doctors. More and more members of the public are looking to hospitals for health service. This contact service emphasizes the tie-up between the hospital and its staff, helps the public to associate physician and hospital and is consequently of value to both. The peak load of calls should come at a time when the hospital switchboard is not busy. The financial return helps to pay for the switchboard operators. If the job is carefully and efficiently accomplished it has a favorable effect on the staff member as well as on the public."

First Aid Tent at Fair Publicizes Hospital

Old patients were greeted and new friends made at the Hackettstown Fair, Hackettstown, N. J., by the staff of Newton Memorial Hospital, Newton, N. J., through the agency of a first aid tent.

Uniformed hospital nurses gave first aid, as well as information about hospital service. They were assisted each evening by volunteer local nurses.

Hackettstown is in Warren County and the hospital is in Sussex County. Charts posted in the tent showed the percentages of citizens served by the hospital in both counties. Fifty-three per cent of all accidents cared for at the institution occurred to residents outside Sussex County, it was revealed.

The hospital was able to give this service at little expense. The tent was furnished by the fair association, a truck was donated by a local garage and a hospital employee made all the signs announcing the service.

The tent was decorated with photographs and exhibits of the hospital and its ambulance service. A little girl lent her big doll to demonstrate the hospital's method of identifying the newborn, and the bassinet it occupied was a major attraction for children and their parents.

Charlotte Janes Garrison, who was then superintendent of the hospital, and several of her nurses were responsible for the first aid nursing service.

Better Refrigeration — Less Electricity

At one time it was the practice in Glens Falls Hospital, Glens Falls, N. Y., to shut off the motors of the electrical refrigerating units regularly each Monday morning in order to defrost the coils. It was finally decided, according to Rose Q. Strait, superintendent, to change this plan a bit and to shut off the motors two hours every night from midnight to 2 a.m. During the winter it has even been found possible to shut down from four to five hours each night. During the summer the time has had to be reduced on occasion to one hour. "The experiment proved highly satisfactory," states Miss Strait. "It gives a more even defrosting, decreases the use of electricity and 'rests' the motors for longer periods."

And Further Affiant Sayeth Not

The case of Herbert S. Troyer, plaintiff, *versus* Two Enlarged, Obstreperous, Obnoxious, Unruly and Entirely Undesirable Thyroid Glands, defendants, in the Berwyn Hospital of Cook County, Illinois, has attained at least local renown. An eighteen-page Brief for Plaintiff has been drawn up and printed in pamphlet form, bringing amusement to Mr. Troyer's friends and incidentally good will to the hospital.

The brief contains a statement of the case, three chief points and authorities for them, the argument with its conclusion by counsel for the plaintiff (his physicians and surgeons), Appendix A, containing the opinion of the court, and Appendix B, a statement by the plaintiff.

Probably you can think of one or more practical ways to save time or increase efficiency. The Modern Hospital will welcome your ideas to put before other hospitals

The Jewish Attitude Toward Autopsies

It is the hope of every medical scientist that those who are loyal to the traditional spirit of Judaism will adopt the more liberal interpretation of the law and modernize the severe restrictions that are insufficiently grounded in Jewish law and forbid many necessary examinations

By MILTON PLOTZ, M.D.
Brooklyn, N. Y.

EVERY hospital administrator and every medical man of science sooner or later comes to the point where he must ask consent to examine the dead for the purpose of determining the reason why death occurred. The prejudice that controls many lay people in this respect is not only a restraining influence on the progress of science but a discouragement to those who did their best that the patient might live.

In order to overcome these prejudices, which are largely on a religious basis, the administrator or the physician must be informed regarding their origin. Prejudices may be overcome by reason, by an appeal to the emotions or to sentiment, but the responsible relatives of the dead should never be pressed for consent on terms that are on a lower level. Considerate and reasonable explanations are in order and, in the present state of our knowledge, are the most successful in securing consent.

The objections of the layman, as I have pointed out elsewhere,[1] are often based on tradition, sentiment, malicious rumors, careless references by physicians and very often on religious scruples either sincerely set forth or used as an excuse for a negative response. The religious factor is particularly important among the orthodox, Jew or Gentile. It is with the Jewish point of view that I am concerned in this paper. Many hospitals, particularly those under Gentile management, experience difficulty with Jewish families. There is, indeed, considerable variation in the percentage of consents obtained in hospitals from orthodox Jews. In some Jewish hospitals there is an exceptionally high percentage of consents which place them among the first in the country in this respect.[2] On the other hand, a commission in Pennsylvania has announced that many hospitals find it impossible to secure an autopsy on a Hebrew.[3]

It would seem to be in order therefore to devote some space to an exposition of the orthodox Jewish attitude from the developmental point of view.

There is one factor that must be borne in mind and this is that the Jewish people are divided into denominations and are no longer agreed among themselves on religious questions like these. Individual members of the Jewish community will not often recognize the rulings of groups other than those with which they are affiliated. We find, for example, that the Central Conference of American Rabbis and most members of the United Synagogue of America, which are liberal (reformed) and conservative bodies respectively, are sympathetic to the postmortem idea. The mistake must not be made of assuming that a favorable opinion from a rabbi of one of these groups is the authoritative attitude for all other groups, or that there is no real religious objection on the part of some whom we shall have to approach for consent.

Consultation With Rabbi Is Helpful

Rabbi Leventhal of Philadelphia, a recognized leader among orthodox American groups,[3] made it clear about ten years ago that he regarded autopsies as permissible, yet many Jews will not accept his pronouncement as final, especially when certain equally important orthodox leaders are opposed to postmortem examinations. A sympathetic understanding of the orthodox viewpoint, coupled with authority from the local rabbi, will often be effective in persuading a Jewish family to consent to postmortem examination.

Postmortem examinations are not mentioned in the Bible, but we believe, by inference, that incisions of the body were permitted since Jacob and Joseph were embalmed,[4] and the method of embalming in those days, it is said, involved the removal of certain viscera.[5] We can trace almost all later discussions in the Hebrew literature to one page in the Holy Writ: "And if a man committed a sin for which there was punishment of death and thou hang him on a tree, then shall his

body not remain all night on the tree, but thou shalt surely bury him on that day, for he that is hanged is a dishonor of God and thou shalt not defile the land which the Lord thy God has given thee for an inheritance."[6]

The Talmudists deduce from this that if a sinner must be buried on the day of his death then certainly the body of a non-sinner must be laid to rest (that is, not dishonored) within twenty-four hours. From this premise the tradition evolved over the centuries that anything which might be considered an offense to the dead (in Biblical language, "nibul hameth") is strictly forbidden. For many centuries the autopsy was no longer mentioned in Hebrew literature. As a matter of fact, according to Spivak, there is no mention of autopsy in the modern sense of the word until the last two and a half centuries. References are made to dissections by rabbinical students in Talmudic times, but are not, however, derogatory.

During those days an elaborate set of laws and customs were already developing which had for their object the prevention of the desecration of the dead. From these the idea developed that any incision of the body was a disgrace to the deceased. Also during this time, reasoning from the Biblical injunction "you shall bury him" the precedent was established of burying the entire body. Hence the present objection to evisceration.

In the latter part of the eighteenth century a case was brought before a famous rabbi and almost all subsequent cases have been based on his decision. An operation had been performed on a patient suffering from bladder stone and after his death the surgeons approached the family for permission to perform an autopsy, or rather what we should call nowadays a wound inspection, on the ground that a knowledge of their mistake would help in performing similar operations.

Saving a Human Life

The relatives turned to the distinguished Rabbi Ezekiel Landau[7] for a ruling. He said, "When it concerns the saving of a human life there can be no question of the permissibility of an autopsy, because the saving of a human life supersedes all commandments of the Bible, except three, the shedding of blood, lust and idolatry. In this case, however, there is no sick man present who needs to be cured immediately. For the sake of a similar case that might happen in the future, we are not permitted to transgress an injunction of the Torah, for we should minimize the importance of autopsies, God forbid, and they would be practiced on all the dead indiscriminately."[8]

From this decision evolved the orthodox Jewish attitude, which has been summed up by Spivak as follows: "(1) Autopsies are not permitted when they are an indignity to the dead. (2) Autopsies are permitted when they are an honor to the dead. (3) Autospies are permitted when a human life can be saved thereby, for instance, when there is present a sick man who suffers from the same malady from which the patient died. (4) Autopsies are not permitted for purely experimental purposes, that is, 'when the sick are not before our eyes.'"

This represents, however, the orthodox point of view only and, in the opinion of the more liberal of the Jewish faith, the autopsy is permitted when information that may be gained by it could be of service to any individual in the present or in the future. This has been the rule of many rabbis. Moreover, the telephone and other modern methods of communication have made possible the rapid dissemination of information so that patients throughout the world may take advantage of any new discovery almost immediately. For this reason many authorities hold that there is no longer the necessity to have the patient "before our eyes."

A Modern Ruling

The opinion of Rabbi Leventhal, mentioned above, may be quoted to those who wish a modern American ruling. He wrote, "I desire to state that unquestionably the dissection of a corpse is not prohibited where a reputable physician believes that it is essentially for the advancement of medical science. Where a postmortem examination may result in the discovery of the origin or cause of some serious disease, it is my firm conviction that thus to serve humanity is sanctifying rather than desecrating the dead." An opinion from some local rabbi should also be in the hands of every pathologist or hospital administrator. It should be noted at this point too that in some European cities the Jewish community has voluntarily delivered bodies of its dead to the universities for dissection in order to discharge what it considered to be its civic responsibility.[9]

A tactful and sympathetic approach to this delicate problem is of exceeding importance and a sincere desire to interpret the traditional attitude should go far to convince those who, out of "religious" reasons, stay the hand of science.

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Administrative Tact and Trusteeship

By B. C. MacLEAN, M.D.
Director, Strong Memorial Hospital, Rochester, N. Y.

THE names "superintendent," "director" or "administrator" are as synonymous and interchangeable as the several terms for "spinster" or the various culinary names for bean soup. If, however, the incumbent has the true essentials of his office, a sense of humility and a sense of humor, he will be content to be called by any one of them, knowing well that after all he is expected to be a combined innkeeper, sergeant major and diplomat.

In his relationship to the governing board, the third rôle is perhaps most important, for he must lead and be led by the trustees who employ him. It is often said that the personality of an administrator is reflected in the character of his institution. This is true to the extent that a governing board permits. For the administrator it is the part of wisdom to take the kicks and let the governing board have the ha'-pence.

Steering a Middle Course

In general, the board should concern itself with policies and the administrator with practice, but many are the variations of such a principle, depending on the structure of organization, the type of control and the strength of personalities. Not infrequently trustees recognized for their ability, judgment and business sense, fail to understand that a hospital, while not a business, must be conducted in a businesslike manner. No description is needed of the trustee who accepts appointment or election to a governing board but never shows any further interest. Well known, also, is the sincere but self-deceived trustee who suffers from meddler's itch and snoops around the ice boxes on Sunday morning.

Between the trustee who does too little and the trustee who does too much, there is the one who is always available for assistance and advice, who is impartial in his attitude and who is sympathetic in his approach to the problems of the multi-ringed modern hospital circus. His shoulders carry the burdens of trusteeship of the hospitals of the country. He is the one who is interested in knowing whether the hospital is playing fair with the public, the profession and its own personnel. He wants to know whether nurses should be educated to be pseudo-university professors or trained to be real nurses, whether staff appointments should be made on merit or on bulk of private practice, whether hospital care should become a pawn of politicians and whether the voluntary hospital system must become just another alphabetical unit in the government spree of bureaucracy. These and many other things he is anxious to know and it is the administrator's duty to keep him informed.

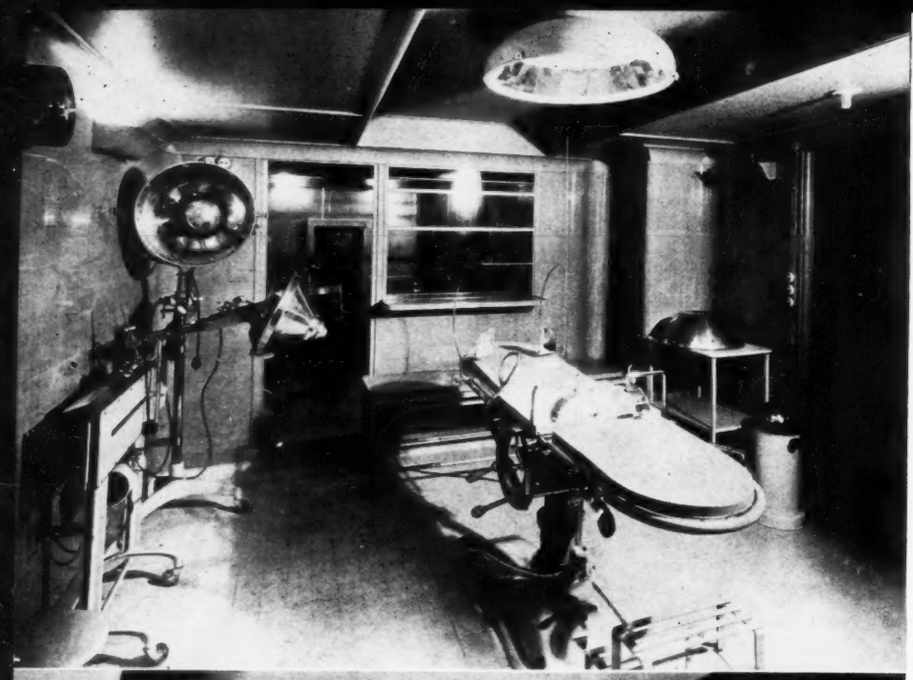
We are all familiar with the difficulties experienced by able and conscientious administrators in hospitals where politics rears its ugly head. The federal institutions of the United States rank high in every respect. There are also some extremely well administered state, county and municipal hospitals in this country. There are still many, however, where the administration must be "subservient to the personal and party interests of political leaders." As Matas pointed out ten years ago, "the taint of politics, when it touches a hospital, permeates all of its departments; but perhaps in none more disastrously than in lowering the standards and efficiency of its service."

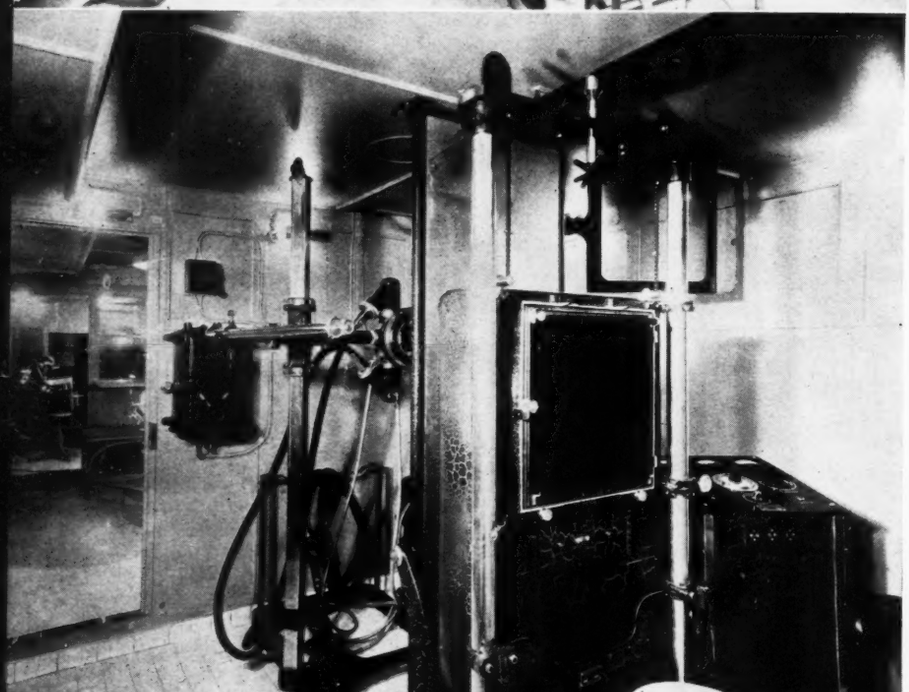
Board Meetings Too Dull

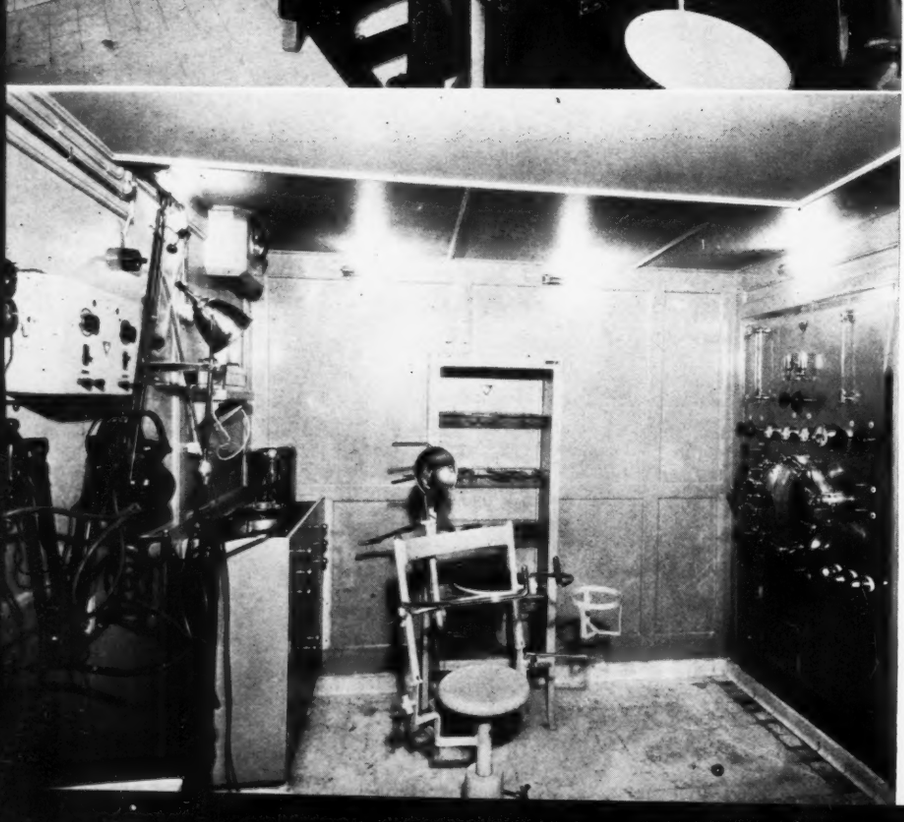
Too often the meeting of the governing board is taken up with a series of drowsy financial and statistical reports. Too seldom is it a color movie of a hospital's work, its successes and failures, its hopes and ideals. A human interest story has been known to make a keen worker out of an apathetic trustee.

The administrator, of course, should always be an ex officio member of the governing board and of its standing and special committees. Indeed, he should be the recognized medium between the board and the staff and personnel. Without such recognition and its attendant responsibility and authority, his path may be precarious. An administrator, like a husband, just naturally becomes either a boss or an office boy. On firm footing is an institution where the relationship of the administrator and the governing board is marked by the frankness, confidence and tact that lead to smooth running of the hospital machinery.[1]

[1]Abstract from a paper which was part of a symposium on "The Hospital Administrator" presented at the meeting of the American College of Hospital Administrators, St. Louis, September 30, 1935.







Medical Care on the High Seas

THE emergency hospital facilities found on the *S. S. Normandie* strikingly exemplify modern scientific advances. The medical care division is in three parts—a hospital unit for passengers, 35 beds, another of similar size for members of the crew and a medical and surgical clinic. Modern technical equipment has been installed. The physiotherapy appliances consist of a short wave diathermic machine with two 250-watt bulbs for local and regional applications and an actinic shower with a movable lamp operating on rails. A complete x-ray installation is available for doctors who wish to examine patients for bone fractures and other internal disabilities, through both radioscopy and radiography. Emergency dental treatment is also provided for. The hospital staff is made up of three physicians and seven nurses. An interesting feature of the hospitalization section is a tiny chemist's shop, near the entrance to the clinic. At the top of the page is shown the operating room. In the center is the x-ray room and the bottom picture shows a dressing room.

Letting Reporters in the Front Door

HOW may a hospital give information to newspapers and not become entangled in medical ethics? This is a difficult problem and one not always easy to decide. Newspapers claim, and not without justice, that accidents to prominent persons are news and that it is in the public interest to make such news available. Medical societies, with equal right, declare that often newspaper publicity is used by borderline physicians to build up a reputation that is not deserved. Patients sometimes object to the type of news stories written about them.

To meet this situation fairly to all parties, a joint committee of the Hospital Council and the Academy of Medicine of Cleveland has been meeting for some months with representatives of the Cleveland newspapers. Out of these meetings has developed a list of the items of information that may be given out to newspaper reporters.

The report is divided into two parts, the first dealing with police cases and the second with other cases. For either type of case responsibility for providing information is to be placed on one individual in the hospital to whom all inquiries are to be directed.

Rules Governing Police Cases

For police cases the following items of public information may be given without the patient's consent:

1. Name: (a) Married or single, (b) color, (c) sex, (d) age, (e) occupation, (f) firm or company employing patient and (g) address.

2. Nature of the Accident: (a) Injured by automobile, explosion, shooting; (b) if there is a fracture, it is not to be described in any way except to state the member involved, and (c) more than a statement that it is simple or compound may not be made.

3. Injuries of the Head: (a) Simply a statement that the injuries are of the head may be made; (b) it may not be stated that the skull is fractured; (c) no opinion as to the severity of the injury may be given until the condition is definitely determined, and (d) prognosis is not to be made.

4. Internal Injuries: (a) It may be stated that there are internal injuries but nothing more specific as to the location of the injuries, and (b) a statement that the condition is very serious may be made.

5. Unconsciousness: (a) If the patient is unconscious when he is brought to the hospital, a statement of this fact may be made; (b) the cause of unconsciousness, however, should not be given.

6. Cases of Poisoning: (a) No statement is to be made that a patient is poisoned; (b) no information as to kind of poisonous substance, such as mercuric chloride, phenol or carbon monoxide may be given; (c) no statement concerning the motive, whether accidental or suicidal, may be given, and (d) no prognosis may be made.

7. Shooting: (a) A statement may be made that there is a penetrating wound; (b) no statement may be made as to how the accident occurred, *i.e.* accidental, suicidal, homicidal or in a brawl, nor may the environment under which the accident occurred be given.

8. Stabbing: The same general statements may be made for stabbing as for shooting accidents.

9. Intoxication: No statement may be made as to whether the patient is intoxicated or otherwise.

10. Burns: (a) A statement may be made that patient is burned, also the member of the body involved; (b) a statement as to how the accident occurred must be made only when the absolute facts are known, and (c) no prognosis may be given.

11. Attending Physician: Hospitals may state to the representatives of newspapers, the name of the attending physician of private patients and refer such representatives to the physician for information about the case.

12. Pictures: When newspapers request the privilege of photographing a patient in the hospital, such permission will only be given (a) if in the opinion of the doctor in charge of the case, the patient's condition will not be jeopardized, and (b) if the patient (or in the case of a minor, the parents or guardian) are willing to have a photograph taken.

For other than police cases the following rule has been adopted: "If the patient is conscious and can communicate with the doctor or nurse in charge, or relatives, he should be asked whether he will permit any information to be given and his decision is final."

Better Mutual Understanding Expected

If the patient agrees to permit information to be given the conditions are identical with those quoted above except that item 3 (c) does not permit an opinion to be given as to the severity of head injuries even when the condition is definitely determined, items 6, 7 and 8 permitting certain information on poisoning, shooting and stabbing are omitted and item 11 is qualified by stating that "the newspapers shall not use the name of the physician without his sanction."

The Cleveland newspapers count the efforts of the joint committee as evidence of a new attitude of cooperation. Reporters can now come in the front door of the hospital for their information instead of, figuratively and sometimes literally, coming in the back door.

Giving a Background of Comfort to

By KATHARINE J. DENSFORD, R.N.
and
STIRLING HORNER, A.I.A.

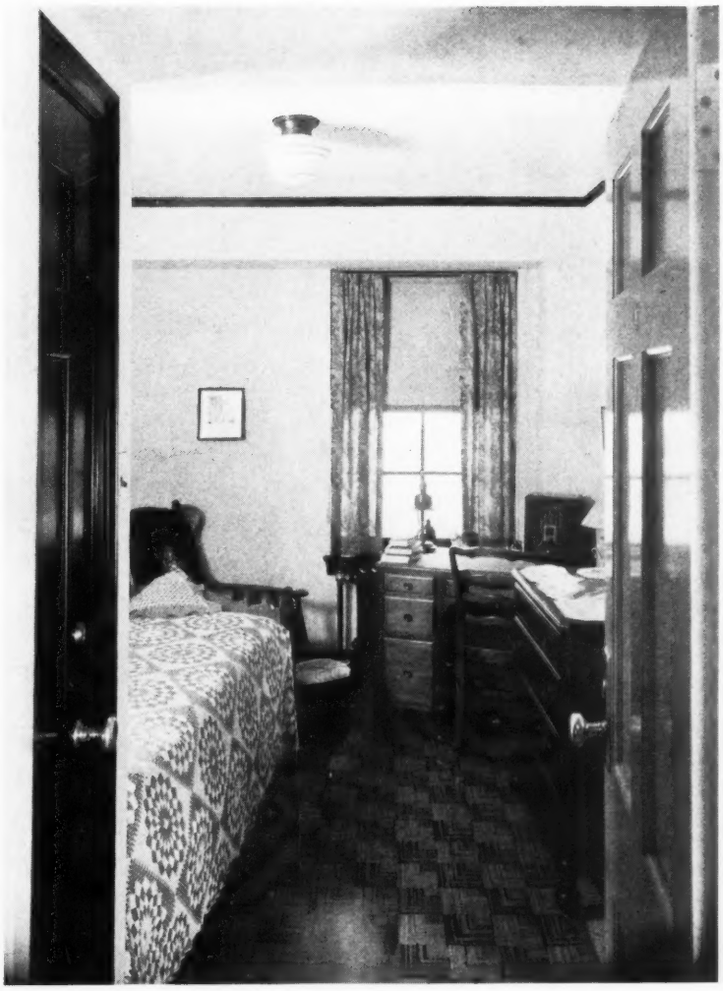
Director, School of Nursing, University of Minnesota, and Architect, St. Paul, Respectively

THE English specialist in housing, Octavia Hill, has called attention in modern times to the need of proper housing. She pointed to the relation between good housing and efficiency. It would be trite to emphasize this relationship today and yet in large measure the new nurses' hall at the University of Minnesota is an outgrowth of the recognition of such a relationship.

Founded in 1909, the school of nursing for almost a quarter of a century housed its students

The nurses' hall at the University of Minnesota is designed in Georgian colonial style, carried out in reddish brown brick, trimmed with limestone. The roof is of variegated colored slates. The lower picture shows a corner of the courtyard, which overlooks the Mississippi River and the winding drive on its east bank.

the Nurse's Job



View of a student's room, taken from the hallway, showing the closet behind the door at the left. The lavatory is behind the door at the right. Individual rooms are 9 by 10½ feet, exclusive of the clothes closet and lavatory space. The furniture consists of a standard single bed of wood, a small desk, a dresser, an upholstered easy-chair and a straight backed chair. A room sized rug is used.

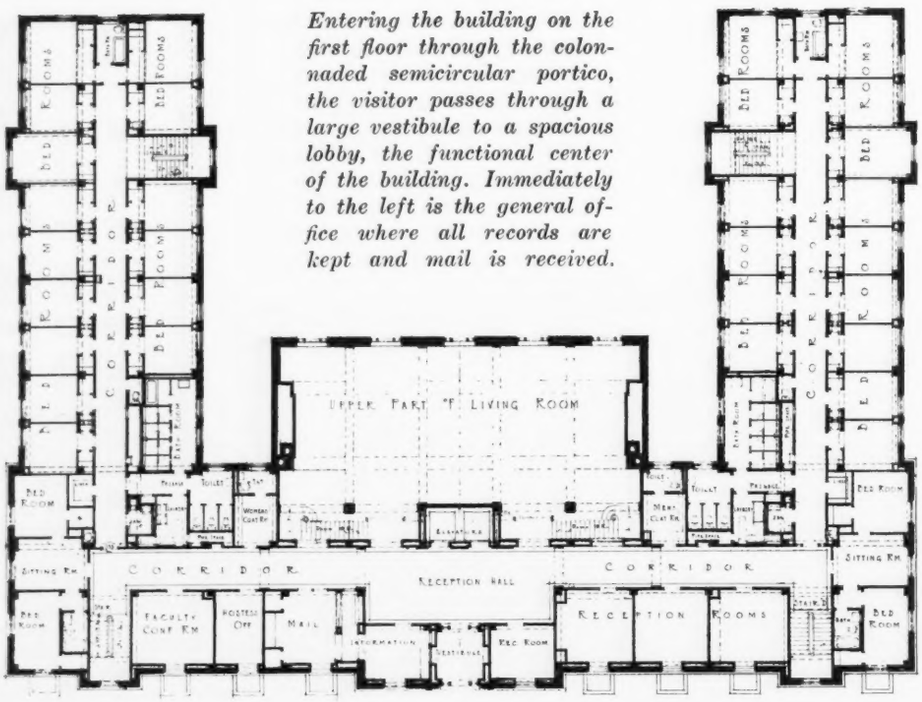
and graduates in makeshift buildings, some fifteen of them in 1933, scattered about the university campus. For almost the same period of time plans had been under way to secure legislative appropriation for a residence for the nurse students.

Many persons believing that comfortably housed students and graduates give more satisfactory care to patients, have through the years contributed largely of time and effort in the forwarding of plans for a new building. Those most earnestly active in the project were Dr. Richard Olding Beard, founder of the school; Louise M. Powell, director of the school from 1910 to 1924; Marion L. Vannier, director from 1924 to 1930; Paul Fesler, superintendent of the University Hospital from January 16, 1927, to June 30, 1932, and numerous friends and members of the alumnae association.

The nurses' hall was designated to be built second of several buildings approved by the legislature April 25, 1929. The board of regents approved final plans for the building April 21, 1932, and accepted bids May 25, 1932. The corner stone was laid October 13, 1932, and the dedication of the building took place October 27, 1933.

The site chosen for the new building is at the end of Union Street at its intersection with Essex, which parallels the property. The plot was rugged, sloping sharply from Essex Street to the River Drive, some two hundred and fifty feet distant, and at this point twenty-five feet below the ground level at Essex. It is immediately adjacent to the Cancer Hospital of the university medical group. Obviously the topography of the property influenced the arrangement of the plan to a marked degree. The front portion on the Essex Street side of the building is a full story below ground level, whereas in the wings, the so-called ground floor is well above the lot grade. It should also be noted that in the development of the plan scheme serious consideration was given to the need for future extension of the building to the east.

The plan finally adopted is U-shaped, 175 feet wide fronting on Essex Street, the east and west wings extending 126 feet southerly toward the River Drive and overlooking the Mississippi River. Entering the building through the colonnaded semicircular portico, one passes through a large vestibule to a spacious lobby, the functional center of the building. Immediately to the left is the general office. Here all records are kept, nurses checked in and out, mail and packages received and pigeonholed and telephone calls handled. Adjoining is a reception room and the faculty conference room. To the right of the lobby is the office of the director of the building. Adjoining are two reception rooms, provided for use of the nurses and their guests.

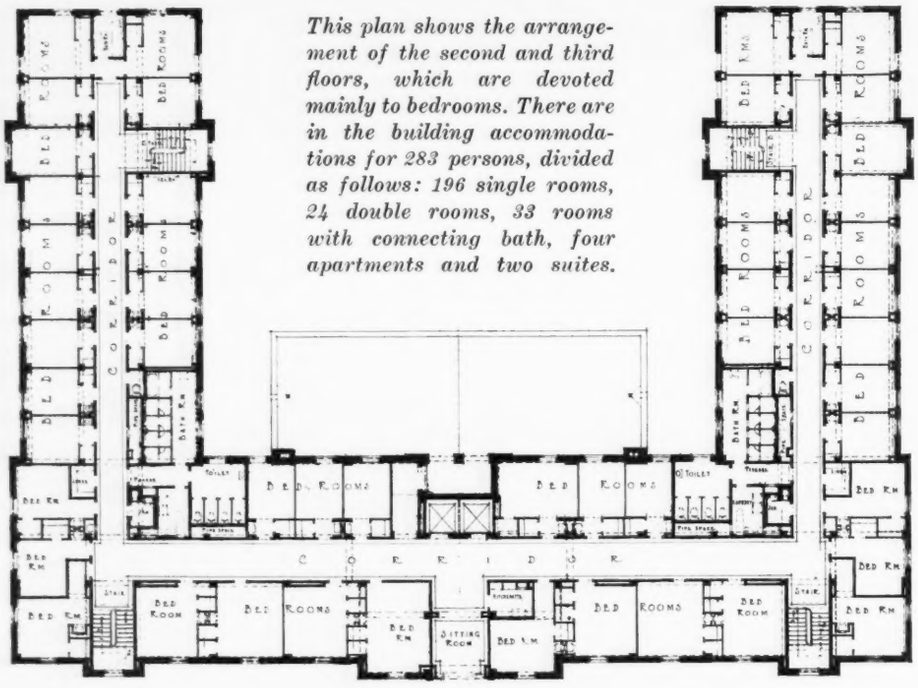


Entering the building on the first floor through the colonnaded semicircular portico, the visitor passes through a large vestibule to a spacious lobby, the functional center of the building. Immediately to the left is the general office where all records are kept and mail is received.

Two elevators are located directly across the lobby from the main entrance. At either side of the elevators, iron railed arched openings overlook open stairways leading down to the nurses' living room or lounge. This is a room of magnificent proportions. It occupies the center of the building between the wings on the river side. Looking out over the stone paved gardens of the court, through the high arched windows, the lounge commands a lovely view of the Mississippi River and the winding drive on its east bank. This room, wainscoted in brown toned gumwood is 70 feet long, 37 feet wide, and occupies two stories of the building in its height. Great fireplaces, at either end, combined with tastefully appointed furnishings, create an atmosphere of domesticity so often attempted but so rarely achieved in buildings of this character.

Immediately below the lounge and at garden level is the recreation and playroom. This is of the same area as the lounge and has the same orientation. Across the corridor on this floor is a dining room for resident faculty members. This room, however, is used as a dietetic laboratory for the teaching of students. Adjoining is a generously planned serving room, actually used for the teaching of students, which has a combined function of service to the faculty dining room and preparation of food for afternoon teas and other similar entertainment. No other kitchen or dining room facilities are provided in this building as these are adequately cared for in the service building of the main hospital group.

The dormitory sections occupy the center portion of the building through the fourth, fifth, sixth and seventh floors, and the wings in their entirety, save the basement floor of the east wing which houses the laundry and the servants' bedrooms. There are accommodations for 283 persons. The quarters consist of 196 single rooms, 24 double rooms, 33 rooms with connecting bath shared by two or three rooms, four apartments and two suites.



This plan shows the arrangement of the second and third floors, which are devoted mainly to bedrooms. There are in the building accommodations for 283 persons, divided as follows: 196 single rooms, 24 double rooms, 33 rooms with connecting bath, four apartments and two suites.

At the outset it was decided that in the main, the nurses should be quartered in cheerful, individual rooms, with a small proportion of double rooms. Exhaustive study was given to the size and appoint-

ment of the individual unit. The plan, as finally adopted, provides a room, 9 by 10½ feet, exclusive of the clothes closet and lavatory space. Each room was studied for the placement of furniture which consists of a room sized rug, standard single bed of wood, a small desk, a dresser, one upholstered easy-chair and a straight backed study chair. Clothes closets are approximately three feet square and lavatories are set in recessed niches, independently lighted and equipped with mirrored cabinets and two towel bars. The double rooms are similar, but of larger size and have two clothes closets, as well as a complete additional set of room furniture.

The supervisors' rooms vary in arrangement, all having bathroom accommodations arranged for the most part between two rooms, which with the bath forms a double suite. On the seventh or attic floor, exclusively a supervisors' and head nurses' floor, all rooms, thirteen in number, are of the double suite and bath type. Two independent suites, consisting of living room, bedroom, bath and small kitchenette, are also on this floor. These suites, with their attached roof terraces, have a splendid view of the river valley.

Each wing on each floor has its own toilet, bathing and service section. This unit consists of separate toilet and bathing rooms, a small laundry, a linen room and a janitor's service room, which includes connection to the incinerators. A comfortably furnished sitting room is well placed in the center section on each floor and adjoining it is a small kitchenette for the use of the nurses.

The building is connected with the adjacent hospital group by means of a passage tunnel at basement floor level.

The structure is designed in the Georgian colonial style, executed in reddish brown brick which harmonizes with that of adjacent buildings, trimmed with limestone. Roofs are of variegated colored slates. Interior woodwork is of stained or painted gum wood. Door frames are of shaped steel. The floors are of terrazzo except the lounge which has a wood floor and the toilet and bath sections which are of ceramic tile. Community bath, shower and toilet rooms are wainscoted with marble and private baths with matt glazed tiles.

The cost of the structure was divided as follows: building and fixed equipment, $325,552.57; movable equipment (furniture and furnishings), $45,034.74; land (two parcels), $47,703.50; total, $418,290.81.

The lounge is wainscoted in brown toned gumwood and is 70 feet long by 37 feet wide. It occupies two stories of the building in height. Great fireplaces at either end and tasteful furnishings create a homelike atmosphere.

The plans were prepared and the construction supervised by Clarence H. Johnston, state architect, St. Paul, who has designed many other important university buildings. The Pillsbury Engineering Company, Minneapolis, are the engineers who provided the mechanical equipment.

Miss Binner Evaluates the Plan

"The first, second and third floor plans of the nurses' hall at the University of Minnesota I found extremely interesting. I viewed them with a critical eye, searching for many essentials too often not provided in a nurses' residence, only to be rather pleased that in this instance these essentials had not been neglected.

"The arrangement of the information desk and mail boxes is good. The first floor reception rooms for the use of nurses and their guests should prove to be in great demand. For this type of room an arched opening, rather than the small doorway allowed, usually simplifies supervision, for whether or not we like to acknowledge it, the need for supervision in a residence still exists.

"The arrangement of the single bedrooms is excellent. The location of the closet and lavatory utilizes a minimum amount of space and leaves good wall space for furnishing the room proper. Where cost per cubic foot must be considered, a single room 9 feet 6 inches in length instead of 10 feet 6 inches, as allowed here, will accommodate the same pieces of furniture. Naturally, spaciousness in either case is out of the question. The reason for planning double bedrooms is not obvious, nor has this been explained in the accompanying description of the residence, single rooms generally being considered more desirable from the point of view of health, also allowing for privacy, which should be necessary to all persons who are constantly being taxed both mentally and physically.

"Ample bathing and toilet facilities have been allowed. Separating toilet rooms and bathrooms is highly desirable. The laundry room on each floor should prevent, or at least reduce to a minimum, laundry work done in rooms. The kitchenettes on each floor will also prove popular. These are conveniences which do not add greatly to the cost of a building but which are deeply appreciated by all women.

"The provision for janitors' closets does not seem to be generous, only two to a floor to serve three long corridors. On the floor plans submitted to me there is no provision for trunk storage. This is probably provided elsewhere, although storing luggage on each residence floor rather than in one central storeroom has many advantages."

A Protective Coating for Paint

The old painters' custom of using starch or buttermilk over the final coat of paint or glaze is one well worth perpetuating, in the opinion of George Diehlman of the National Lead Company laboratories.

The procedure served several purposes, Mr. Diehlman points out. It was an aid in getting uniform flatness, which rendered brush marks and shiners inconspicuous. It protected the paint film from dirt and discoloration. Because it was water soluble, it was easily washed off, leaving the paint with its original brightness and good appearance. In many cases when the walls were not cracked or the paint badly marred, all the painter did to complete the job was to apply another coat of starch or buttermilk.

Except among decorators who wish to protect the more costly decorative effects, this practice has largely been discontinued in recent years, according to Mr. Diehlman. He believes, however, that the great increase in the use of paint on plaster and the higher labor cost of today should make the use of starch sizes on wall paint coatings more popular.

It should be understood, of course, that all wall paints are not susceptible to a satisfactory washing even when protected by starch or buttermilk size. However, where white lead and a flatting vehicle make up the paint, the renewal of the surface appearance by washing is perfectly feasible.

Starching, while not essential on white lead flat paints, has the advantages before mentioned of giving softening effects in the paint or decoration and rendering less noticeable small imperfections in application. The same procedure is employed where starch is to be used for overcoating purposes, as in making flour or starch paste. However, it should be thinned somewhat for use as a size, to permit brushing out in a thin, even film, Mr. Diehlman states.

Occasionally, in applying starch solution or buttermilk over painted walls, one encounters a surface tension effect where the liquid is drawn from the immediate surrounding area into large droplike pools, thus leaving uncovered portions, the general effect being like drops of water on a buttered dish. This so-called crawling phenomenon can be overcome by adding about eight ounces of soap flakes to each gallon of starch solution (or buttermilk) and stirring until the soap is completely dissolved. This mixture, when applied, will usually be found effective.

When the paint has been formulated with white lead and lead mixing oil, the presence of soap in the protective coating of starch or buttermilk makes the subsequent washing down process easier when renovating becomes desirable.

Suggestion for Painters

Less cleaning up after painters will be necessary if the workmen put a thin coat of soap on glass, metal or tile that adjoins surfaces to be painted. This coating prevents the paint from sticking where it is not wanted. It may be quickly removed with soap and water after the new finish has had time to dry thoroughly.

What the Superintendent Should Know About the Maternity Unit*

Appointed and courtesy obstetric staffs—normal and full obstetric privileges—residents in obstetrics and interns, what are their rôles in the maternity department? These topics, along with prenatal and postnatal clinics, furnish the material for this article, a sequel, as it were, to last month's presentation

THERE are two plans for the medical staffing of the maternity department. In the first there is a specialty hospital staff made up of physicians ranking high in the practice of obstetrics and gynecology. No other community physicians are permitted to practice in these hospitals. All patients are referred either by outside physicians or by the offices of the appointed staff.

One would expect that mortality and morbidity statistics in such institutions would be very low. Such is not always the case. There are various explanations. Naturally the more difficult types of obstetric complications would be referred to such a hospital. Moreover, probably community physicians are inclined to endeavor to deliver their patients at home rather than refer them to another physician.

Such a set-up certainly does not increase the efficiency of community obstetrics because the family physician does not have an opportunity to enlarge his experience in the handling of the pregnant woman under the best auspices.

In another type of hospital there is an appointed staff and also a more or less loosely organized courtesy staff. In still another type no staff is appointed by the board of trustees but all accredited physicians in the community are permitted to practice institutional obstetrics therein.

The management of the courtesy obstetric staff presents many difficulties. Physicians appointed to this group should be carefully selected. Application forms setting forth professional and personal qualifications should be required and these should be scrutinized by the qualifications committee of the appointed staff. Courtesy privileges should be granted upon recommendation of this group, by the medical officer in charge of the hospital or by the board itself or by all three.

All members of this staff are not equally qualified to perform the major and minor procedures necessary to the delivery of the pregnant woman. In most institutions a division of privileges is made, these being classed as normal and as full obstetric privileges. The crux of the situation centers about the description of these classifications. The privilege of practicing normal obstetrics is usually granted to the family practitioner, the type of physician who has not been given an opportunity to perfect himself in such complicated procedures as the application of high forceps, and the performance of version and cesarean section. He is permitted to employ low forceps, to repair first degree tears and, rarely, to perform versions.

Limiting Those With Normal Privileges

It is of the utmost importance that careful scrutiny be given to the qualifications of physicians who desire full obstetric privileges. Usually only physicians who are on the major staff of other hospitals or who hold positions on a medical teaching staff or who have definitely specialized in obstetrics are granted full obstetric permission.

Even with such a carefully worked out classification, difficulties are certain to arise. A physician possessing but normal obstetrical privileges finding delivery delayed is inclined to request high forceps for application, to attempt to perform a version or even to schedule a cesarean section. No hospital is performing its full duty to its community which permits a physician with uncertain training to endanger lives by attempting procedures for which he is not prepared.

It becomes necessary, therefore, to draw up rules governing the practice of this first group. Many institutions require that in all cases where labor is continued longer than eighteen hours, a

*Practical Administrative Problems Series.

consultant from the regularly appointed staff must be called. This consultant usually serves without fee and his service to a less experienced colleague is considered as a part of his general obligation to the hospital.

In some cases, such a consultant may charge a fee if the patient is able to reimburse him. When such is the case, he should be permitted to submit a bill. It is also frequently stated that no intern or resident physician may deliver a private patient of the courtesy staff. There is sometimes a tendency on the part of the latter to step aside and allow the younger, though better trained obstetricians, to assist them when difficulties arise.

Strict observance of rules as to gowning, scrubbing and hand washing should be required of the courtesy staff. The execution of all prenatal records should also be strictly required of this group. Gowning before entering the nursery is considered a basic and important regulation. The relation of the courtesy staff to the appointed staff, therefore, consists of a friendly spirit of cooperation with not a little of a general supervisory status being also present on the part of the latter. Sometimes the courtesy staff has an organization of its own with an elected chairman and secretary. When such is the case, communications relative to matters affecting this group are easily made.

Temporary Courtesy Privileges

Where a large group of courtesy physicians are to be found, such as is the case of one Eastern hospital of 400 beds where 125 physicians are members of this staff, difficulties of supervision are certain to arise. It is questionable whether there is any real necessity for the existence of a staff of this number. Investigation often discloses the fact that many of these physicians deliver few patients during the course of a year in the hospital on whose staff their names are to be found. It seems more expedient for the courtesy staff to consist of physicians who deliver a certain minimum number of patients annually at the hospital. Those desiring the assistance of the institution only occasionally might be granted temporary privileges or courtesy cards as needed.

It is more difficult to control the family practitioner type of physician who employs the maternity department of a hospital which has no regularly appointed staff. The fully open hospital should require some type of staff organization even though it be of a rather flexible type.

In institutions possessing a regularly appointed staff, the members are likely to rank as both obstetricians and gynecologists. Difference of opinion often arises as to need of a gynecologic staff. In some high grade hospitals gynecology is practiced by the general surgeon on the contention that the pelvic brim is but an imaginary line which like the equator divides the northern hemisphere of the surgeon from the southern realm of the gynecologist. In rebuttal the latter insists that the surgical treatment of diseases of the pelvic organs represents a strict specialty and that the surgeon is less inclined to perform creditable work of this type than is the gynecologist. It cannot be denied, however, that many surgeons are splendidly qualified as gynecologists and that some gynecologists perform capable general surgery. The size of the hospital and the type of its clientele must in a measure determine the advisability of this type of staff specialization.

Qualifications of Chief of Staff

The chief of staff of the obstetric and gynecologic division should be a man of strong personality and good administrative sense and should be capable of handling details. It should be to this physician the medical head of the hospital should look for recommendations governing the organization and functioning of this department. The chief of staff should make himself responsible for the conduct of monthly conferences and in a large measure for the general quality of the work of his colleagues. If possible the obstetric staff should serve throughout the full year.

A resident in obstetrics is capable of furnishing much useful supervisory service to the intern. On the other hand, unless the hospital is able to reimburse the resident in obstetrics for his work, the visiting staff must exert itself to make his stay in the maternity department clinically worth while. The length of the maternity assignment of the intern may vary from three months in the institution with a rotating service to a full year in the specialty hospital. If no resident is available the service of the intern should be arranged on a senior-junior plan so that at no time will the department be staffed wholly by interns without experience. The intern should be permitted to perform normal deliveries only, and even then his activity should be supervised by a resident or by an assistant visiting obstetrician.

It is of the utmost importance that a carefully prepared technique book be found in every hospital. This cannot be too highly detailed. To be sure, it is impossible to standardize the practices of each member of the obstetric staff. Minor variations will surely exist but it should be practicable to set down a major technique covering both predelivery and postdelivery procedures. This book should be carefully kept up to date and each new intern should be required to sign it.

The educational activities of the maternity department are of the utmost importance. Classes of instruction for nurses and interns should be conducted from time to time by members of the visiting staff. Standing orders should be discussed and frequently reviewed and revised. Even such a matter as the methods employed in the care of the newborn presents the greatest of variations.

A few years ago, The MODERN HOSPITAL conducted a study of the care of nursery patients. Almost as many techniques were found to exist as were the number of the hospitals interrogated. Some employed soap and water, some powder, some oil, some all three of these and some used only antiseptic applications. While all of these techniques, no doubt, possess their virtues there surely must be a generally correct method which would possess the greatest advantages and the fewest defects.

Highly Specialized Nursing Required

The nursing in the maternity department must be highly specialized. The nurse in charge should be unusually well trained, tactful, capable and able to direct the work of her subordinates effectively. A graduate nurse in charge of the nursery, another for the delivery room and possibly a third as general floor supervisor should make up the supervisory staff. This group must be duplicated for night work and increased as the size of the department requires.

An attempt has been made to set down the nurse to patient ratio. In some institutions it is believed that four students are capable of performing the work of three graduates, that there should be no greater ratio than one nurse to five maternity patients during the day and one to ten during the night and that the nurse to baby ratio should never be less than one to five. Of course, the type of hospital and the capabilities of the nurse may alter these ratios considerably.

The members and type of the personnel necessary in the delivery room are also of much importance. It is believed by many that one supervisor, one unclean and one clean nurse should comprise this team.

Careful supervision of the health of maternity nurses should be maintained. It is, of course, incorrect for nurses with tonsilitis or any type of infection of the hands or arms or any other transmissible condition to care for obstetric patients. In some hospitals where almost perfect aseptic technique has been worked out for resident physicians and nurses it is incongruous to observe members of the visiting staff making rounds ungowned and with little attention to hand washing. Indeed, it appears that the members of the visiting staff represent a difficult group from whom to require careful attention to aseptic technique.

No obstetric department is complete without carefully conducted prenatal and postnatal clinics. Here the most effective preventive medicine principles should be followed. The period of pregnancy is certainly not, as considered by some, a wholly natural and safe time. True it is that many women do not consult the physician until the first stage of labor begins. It is also a fact that our pioneer forefathers besides being hunters and tillers of the soil also became accoucheurs when their wives fell into labor. Nevertheless, the prenatal clinic should be carefully organized. It is probably best that a member of the major obstetric staff should act as its head. It is also desirable for the maternity nurse to supervise this portion of the work.

Here again should be prepared a manual for the conduct of this out-patient activity. Such a procedure book should set down the method and frequency of examinations of patients, the type of history to be compiled, a careful recording of pelvic measurements as well as such danger signs as headache, hypertension, dizziness, edema, blurred vision, vomiting and bleeding.

In the prenatal clinic a splendid opportunity is to be found to make use of the services of the dietitian who should hold regular classes of instruction for this group. Here the type of food proper for the pregnant woman may be carefully explained. The occupational therapy department too may be utilized to assist in the preparation of the layette, and the services of the dentist and of the x-ray department certainly should be sought. A class in the care of the baby should be offered to expectant mothers.

Postnatal Clinics Are Important

When the time for delivery approaches, the technique of admission of the patient to the hospital is of importance. Prenatal records should be promptly available and it is, of course, most inefficient and unsafe for a patient to be taken to the delivery room without the measurement of the pelvis and the medical history of the pregnancy being at hand for the guidance of the physician supervising the delivery.

The postnatal clinic is also of the greatest importance. Here should be supervised the life of the patient for from six to twelve weeks following her discharge from the hospital. Finally, the examination upon discharge of these patients should be most complete. Orders for diet and douches and special treatment to be given at home should be explicitly set down. It is probably wise for each patient to visit either a clinic or the physician's office for three months after delivery.

Editorials

Maintaining Staff Ethics

ONE of the harmful effects of economic stress is a temptation on the part of physicians to lower their previous standards of professional conduct by a tacit understanding between surgeons and community physicians that some type of reward awaits the latter when he refers patients to the former.

The development of a group which interchanges professional courtesies, the requirement for a fee in advance before treatment is undertaken, the promise of a cure for a lump sum, the prolongation of treatment from which no further benefits may accrue, are all evidences of an unhealthy moral tone on the part of physicians.

General hospitals have recently noticed increasing numbers of requests for the admission for treatment of patients suffering from the results of an interrupted pregnancy. Those in authority in the hospital must not be so blinded by the pressing need for an increased income that they do not appreciate that their reputation for the exemplification of high ethical standards is in danger. It is more than difficult to obtain proof of the existence of nonprofessional practices among physicians or nurses. Nevertheless, it is a plain duty of the executive to put forth every effort to maintain the character of the hospital at the highest level.

A Scientific Curiosity

THERE are many hospitals in the field which under the guise of retrenchment have permitted able executives to resign and are attempting to conduct their business without a well trained and capable head. In some instances a member of the board has assumed charge of the institution. In others, the various departments have been assigned to board committees which are responsible for their functioning.

Any experiment if demanded by financial or other urgent necessity is worthy of a trial, but if one untrained hospital head is capable of bringing about disorganization, lowered morale and in the end an increase in hospital expenditure, the confusion which may be wrought by a subdivision of executive responsibility into many parts can hardly be measured.

Even though members of a hospital board are capable of serving both as policy makers and administrators the lack of centralization of authority existent under such a system is appalling. Moreover, trustees concerned with their own private affairs are usually not able to devote sufficient time and attention to the business of the hospital to make their presence and position felt. It is high time, now that panic is subsiding, to return to sane and time tried methods of hospital direction. Well meaning but wholly inefficient board members should decide that it is wise to allow trained executives to function in the conduct of the hospital and should retire to their altogether necessary place as policy makers.

A discouraging feature in the building of hospital administration as a real profession is the lack of appreciation on the part of hospital trustees and the community in general that to conduct an institution successfully requires training, long years of experience and a peculiar psychology which the average business man does not possess. No more inefficient method of hospital administration has been devised than that which allocates departmental authority to individual board members or committees.

City Hospitals and Pay Patients

FROM time to time one hears the opinion that the hospital maintained by the public owes an obligation to its community to provide treatment at a much reduced rate. Again, this belief is practically exemplified in the construction of units to accommodate part-pay patients or even those who are financially able to engage a private physician.

To undersell hospital service in a community where there are ample beds available in voluntary hospitals must be considered a species of unfair government competition. The hospital largely supported from public funds can, without question, provide hospital service at rates impossible for the voluntary hospital. Such a policy might be justified were ward beds in the latter type of institution not available. Moreover, most voluntary hospitals are more than willing to accept ward patients at a fraction of their regular rate. There is no need, therefore, for public institutions to compete with the voluntary hospital which is struggling for existence.

In predepression days when waiting lists existed for beds in privately maintained institutions an argument for cheap and adequate service in a public hospital might have existed. Today this is far from the situation. Unfair government competition whether it be by federal, state, county or city hospitals is but one of the millstones which

are gradually destroying splendid voluntary institutions. Unless the public requires a service that cannot be furnished by privately maintained hospitals, such competition from government sources is to be strongly condemned.

Service and Sales

THE individual who expects to succeed as a distributor of automobiles must maintain a well equipped and constantly efficient repair service. To care for the needs of his clientele, he must not only offer for sale a durable car but he must guarantee that he will maintain it in repair at a reasonable rate after its purchase.

The highgrade hospital begets ever increasing sales. To bemoan falling private room occupancy without seeking a local cause is never wise. Especially at the present time, when everywhere hospitals are reporting signs of improvement in private room patronage, should the excellence of service rendered be closely watched. To be sure, service to patients should continue after the hospital stay is past. But the reputation for up-to-dateness, for the rendition of superservice will attract and maintain a paying clientele.

To retrench is often necessary and usually laudable. But by the same token it is just as frequently the case that to increase incomes, the hospital must spend some money in keeping pleasingly modern. Service begets sales in institutional work just as in more prosaic lines of business endeavor.

Teamwork Between General and Mental Hospitals

THE slightly over 600 hospitals for nervous and mental diseases in this country account for only 10 per cent of the total number of institutions but provide almost exactly 50 per cent of the total number of beds.

In 1928 C. Rufus Rorem estimated that the capital investment in these institutions totaled $820,011,000. Since then it has doubtless passed the billion dollar mark. In 1934 they had an average census of nearly 500,000 patients and an average stay per patient, according to the council on medical education and hospitals of the American Medical Association, of 1,034 days. The average occupancy last year was 95 per cent. Over 90 per cent of the beds are in hospitals controlled by governments, mainly state governments.

Those who have read William Seabrook's recent vivid account of his experiences in a modern mental institution will realize that such institutions well merit the designation "hospital." The best of them are so well administered, so permeated with an inquiring, scientific spirit, and so humane and intelligent in their treatment of patients that they challenge the best general hospitals.

In spite of the extensive facilities now available for the care of these patients, however, it is generally agreed by authorities that only a few states have yet made adequate provision. Hence there is a real place for an adjunct service in this field by general hospitals, provided they are properly equipped and suitably staffed to undertake it. The success of the psychopathic unit at John Sealy Hospital, Galveston, Texas, which is now being doubled in capacity, is evidence to this effect. Even were this not true it would be well for the administrators of general hospitals and of mental hospitals to have a clearer understanding of each other's problems and activities and to exchange helpful experience.

For these reasons, The MODERN HOSPITAL especially welcomes the series of articles on the administration of mental hospitals that is starting in this issue. Being under the aegis of the committee on public education of the American Psychiatric Association and the personal supervision of Doctor Burlingame, chairman of that committee, the series is certain to be authoritative and significant.

Poliomyelitis and the Hospital

FROM time to time cases of acute poliomyelitis appear in lesser or greater numbers in urban, suburban and rural districts in this country. This is, however, neither the time nor the place for an extended discussion of the etiology, diagnosis and treatment of this dread human disease.

Nevertheless, it may be remarked that today little more is known concerning the cause and treatment of this condition than was the case centuries ago. It appears to be a seasonal condition and there is but little doubt in the minds of scientists that it is transferable from the sick to the well. This degree of transmissibility is probably low although from time to time more than one member of a family suffers from this ailment. Some suggestion as to effective preventive and therapeutic measures can be gained from the fact that a virus which probably gains entrance through the upper respiratory tract is now considered by many as the source of the disease.

Cases of poliomyelitis seem to do better in hos-

pitals than at home. The general hospital, therefore, has a definite responsibility to provide for those suffering with this condition. Isolation provisions should be at hand and these quarters should be quiet, airy and somewhat removed from general wards. The presence of paralysis indicates that the specialized attention of the orthopedist is required.

The institution owes to the community the exercise of a highly specialized technique to prevent dissemination of this disease. Approximately the same type of aseptic practices should be carried out as are adopted in the handling of typhoid fever. Occasionally, when respiratory muscles share in the paralysis the necessity for a respirator to maintain life is encountered. The hospital which admits these patients must be prepared for this eventuality.

There should be the closest understanding and cooperation between the pediatrician and the orthopedist. Not only is the hospital in duty bound to provide the proper treatment in the acute stage of this condition but in the distressing months that follow, physical therapy, such as underwater exercise, massage and electrotherapy, should be available. From the contagious standpoint it is wholly proper for the general hospital to accept these patients but once having undertaken their care it should continue its interest until as high a degree of rehabilitation has been brought about as is possible.

Bids and Board Members

THE board of trustees of a representative hospital recently ruled that bids for hospital repairs and new construction would not in the future be received from its own members. This action is eminently wise and just. But to have delayed so long in ruling against the obviously improper is as surprising as it should be unnecessary. That a contractor member of the above group promptly resigned would lead one to surmise that the *quid pro quo* for serving as a hospital trustee in the mind of this gentleman at least was the money making possibilities of such an affiliation.

Legal prohibitions are usually found which interdict a member of a public board or a trustee of a government institution from selling goods to or receiving contracts from the group of which he is a member. In the voluntary hospital the practice of board members placing themselves in the embarrassing position of profiting by their position is to be highly condemned. The board is but the custodian of community funds. To favor one of its own members by not requiring free and open bidding before the purchase of large bills of supplies or prior to contracting for hospital construction is next to dishonest.

To say the least, the practice of politics of any degree or type is sure to soil the good name of the community hospital. When favoritism is shown a board member and bidding is not required or is loosely carried out in the purchasing practices of the hospital the trust of the community is certainly betrayed.

Politics and Hospitals Do Not Mix

POLITICS again rears its ugly head to menace the well-being of hospitals. It is the pay-off time of election promises. The faithful are demanding jobs. In states that conduct public institutions for the mentally and physically ill the position of superintendent of these hospitals possesses a strong allure for him who demands political favors.

Of no importance is the fact that an incumbent has rendered long and faithful service to the community or that he is a valued member of state or national hospital associations. Little counts the past efficiency of a directress of nurses when one who can get out the women's vote but who has no professional training to recommend her, desires her place. The unfairness to the individual counts but little.

The institutional executive who has a definite contribution to make can always earn a livelihood. But the patient — he is the one most harmed. When the soiled hand of greedy politicians touches the care of the sick all that is human and efficiently scientific suffers.

One has but to study the question of executive turnover in these public institutions to learn concerning political methods and their effect on the care of the patient and on the scientific progress of the hospital. It would seem that one remedy for political meddling in hospital work would be the arousing of public opinion by national hospital groups against such practices. The community has its own destiny in its control were it always wide-awake and informed as to need for skilled executives in its hospitals.

Perhaps this reform should be led by the American College of Surgeons, the Americal Medical Association, the American Hospital Association or the American College of Hospital Administrators, or better, by all of them. It surely is reasonable to expect that he who would care for the sick in any capacity should be specifically trained for these duties. Politics and hospitals do not mix.

The Institute in Retrospect

By H. G. FRITZ
Superintendent, Conemaugh Valley Memorial Hospital, Johnstown, Pa.

THE 1935 institute for hospital administrators is a thing of the past and those of us who attended have had time to appraise the end results, and apply to our local problems the specific information gathered. The schedule began at 9 a.m. and closed at 8:30 p.m.

In reviewing the course, certain conclusions as to its benefits become apparent. We return with a fuller knowledge of the work in which we are engaged. No one is entitled to the executive position in a hospital if his knowledge is limited strictly to the balance sheet at the end of the fiscal period. He should know what function each department performs and how it is related to the other departments. When through the failure of any department the work of the hospital is interrupted, he should be able to find the cause and rectify it without calling in an expert. He should have a broad enough knowledge of hospitals to be able to step into another hospital and understand its workings and within a short time should be in control of all the departments.

One cannot expect to acquire this broad perspective within the four walls of one institution. Some executives are so weighed down by the many duties of their positions that they cannot find sufficient time to become thoroughly familiar with hospital work even as it is reported in the various publications. By freeing oneself of all responsibility for a period of two weeks, attending lectures and seminars and hospital inspections, an all-inclusive knowledge can be obtained. In addition to this, there is to be gained the benefit that comes from living, eating and continuously associating with hospital executives from every corner of the country. At meals and during spare time, discussions that arise in reviewing what has been observed and what is being done in other hospitals, bring out many helpful thoughts.

A student at the A. H. A.'s Chicago institute for administrators here sums up his experiences and tells of benefits derived

In spite of a crucial baseball series and daily horse racing, no group skipped hospital visits in order to witness these events, which is an indication of the seriousness with which the students undertook the work.

The students were offered more facts and information than they could possibly assimilate and much which they recognized as similar to that which is in practice in their own hospitals. Some things were observed which are desirable but which would not be applicable in certain hospitals because of physical and other limitations. An important fact learned was that many procedures are not universally applicable and that study is required before important changes can be made. Much information, however, may become helpful when the administrator changes to a new hospital.

Every member of the lecture faculty was a qualified authority on the subject covered. It would be unfair to commend any without a tribute to all. They brought a wealth of knowledge and experience from which the students were offered much in lectures. They were encouraged to draw forth more by questions at the seminars and round tables. If any student returned to his hospital with a question unanswered, it was through no fault of the faculty.

Individual tribute should be paid Dr. Malcolm T. MacEachern for his faithful work as director of the evening round table. He drew from the students many remarks and contributed extensively from his broad knowledge.

Those who attended the institute in 1933 or 1934 found little repetition of the previous year's work, but the afternoon visits to hospitals were counted a definite improvement.

At the hospitals visited, the administrators had reserved their full afternoons for the institute group and had planned interesting programs. Their department heads had prepared demonstrations or lectures in their fields, ranging from x-ray department management and operating room procedures to laundry, housekeeping, and central sterile supplies technique, and the doors of every department were open to the student who

wished to make special studies or observations.

At Cook County Hospital, the institute group attended the regular weekly meeting of the nursing department heads and observed how these meetings are conducted and the type of material discussed.

There was the opportunity to study and observe management and technique in all departments for the purpose of comparison with our own methods, with the result that we can improve our procedures where they are not on a par with those observed. There was a wealth of information to be gleaned about departments and management problems which might not exist in our own hospitals but which will arise if we remodel or build new wings.

Suggestions for Remodeling

When we initiate redecorating and remodeling schemes, our notes will recall for us the color scheme used in the Passavant Hospital or the more modernistic scheme used in the Henrotin Hospital. If we have forgotten any detail of the work observed, we can return to make a more thorough study or correspond with the executives whom we have learned to know through the institute.

The institute offered the opportunity to learn even the most minute details of hospital work. As lectures, seminars or clinics were presented, a mere question by one of the students brought forth an abundance of facts from the administrators and department heads along with contributions by the students themselves. Needless to say, many questions were asked and in some instances, no doubt, the questions furnished amusement by their lack of sophistication.

At Presbyterian, we learned from the anesthetist who has been with the department since its infancy, facts about avoiding explosions when handling inflammable anesthetic agents by grounding equipment.

At Augustana, we saw the newest type of shockproof deep therapy machine and a functioning catalogued pharmacy.

At Cook County Hospital, we witnessed a demonstration in the technique of caring for contagious diseases. If anyone of us already has a contagious disease department or contemplates starting one, Dr. Charles F. Wilinsky's lectures and seminars will help us to determine the status of our department in the community, and we shall know that the person in charge is well fitted if she has taken postgraduate work at Cook County Hospital, or in a similarly conducted contagious disease department.

The lectures and observations on central and decentralized food service will assist us in determining whether or not we should change our present system.

The information to be gathered was not limited to hospitals with a certain number of beds. At round table sessions, material was contributed by representatives from twenty-five-bed hospitals as well as from the larger ones. The hospitals inspected were large and small; general and special; of government and private ownership, and they represented all systems of operation in the functioning of the various departments.

The institute was not without its humorous angle. Some students proved to be tireless collectors of literature and rarely failed to return from hospitals inspected without reams of accounting and chart forms, and any literature which was not fastened to the desks. If they use it, they will derive greater benefit from the institute in the long run.

Residing in the dormitories on the quadrangle of the University of Chicago and having meals in the beautiful dining room of Judson court, were all that one could ask in the way of convenience and lent a cultural atmosphere that did not fail to impress us.

Having the common interest — hospitals — the students found little difficulty in getting acquainted and one did not realize until singing "Auld Lang Syne" at the closing dinner, what pleasant associations had grown up through the brief two weeks.

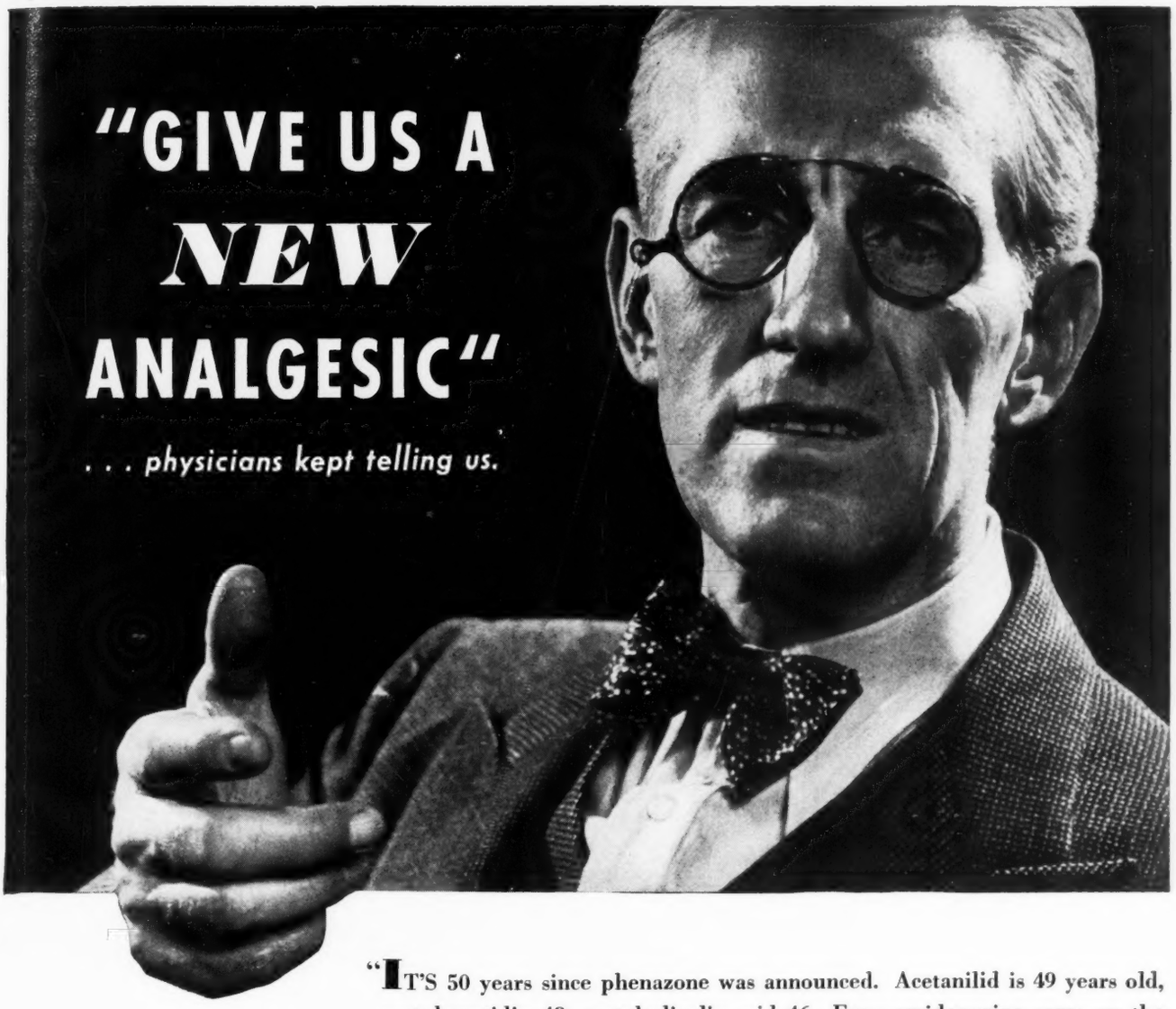
The institute was informative and it was social and no doubt some will return in succeeding years due to both factors.

How to Plan and Equip the X-Ray Department

"What x-ray equipment would you suggest for a 100 or 200-bed hospital?" is a frequent inquiry. It would be folly to attempt to make a recommendation that could apply to institutions according to their respective bed capacities only, according to an article in the thirteenth edition of The HOSPITAL YEARBOOK. "The fact is that two institutions having the same bed capacity may differ widely in their requirements for x-ray service. One institution may be general in character, while the other may be highly specialized.

"Needless to say, the first objective is that of providing facilities with which the department can produce consistently high quality of results, regardless of the quantity of work that it may be called upon to handle in a given time."

The article, which is entitled "Planning the Hospital X-Ray Department," embodies a complete check list of points to be considered in both the planning and the equipping of these departments.



"IT'S 50 years since phenazone was announced. Acetanilid is 49 years old, acetphenetidin 48, acetylsalicylic acid 46. Even amidopyrine came on the market before the beginning of the Twentieth Century. If you want to do something for the medical profession find us a new analgesic and antipyretic, a remedy which will be an honest-to-goodness improvement over these older drugs, a remedy which our patients don't read about in the newspapers." Hundreds of physicians who look always to Roche for new achievements in scientific research have been saying this for the last 10 years. Roche scientists were, in fact, working on the problem long before. Scores of new chemical compounds were investigated. Several would probably have satisfied the requirements and could have been announced prior to 1935. But, just as we wanted to be sure of having the best of all hypnotics in Allonal, so we were determined to bring out only the best of all new analgesics.

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Light Rays Brighten the Doctor's Task

By Robert M. Franklin, M.D. and C. W. Munger, M.D.
Clinician in Tuberculosis and Director, Grasslands Hospital, Valhalla, N. Y.

ULTRAVIOLET lamp therapy is of course no new departure. Since it has come to stay as a therapeutic agent, especially in the tuberculosis and related fields, proper provision needs to be made for the work when new hospitals are built or old ones are modernized. The recent complete equipment of Grasslands Hospital, Valhalla, N. Y., for this form of therapy seems therefore to merit description and discussion. While the equipment described is used mainly for tuberculosis work, the general principles discussed will be of interest to hospitals of various types.

The tuberculosis service of Grasslands Hospital comprises 250 beds for adults and 90 beds for children. A large percentage of all adult patients admitted have tuberculosis of the lungs. An average of 26 per cent of the children have "manifest" childhood tuberculosis, 37 per cent have "observation" childhood tuberculosis, 3 per cent have nontuberculous diseases of the lungs and 33 per cent have no disease, but are undernourished and have had contact with tuberculosis.

Phototherapy is used for the pulmonary tuberculosis itself only in the case of children, but all extrapulmonary tuberculosis receives ultraviolet light in some form. The general rule is to treat the lesion locally when it is accessible, and the body surface generally in addition whenever the pulmonary lesion is not too acute.

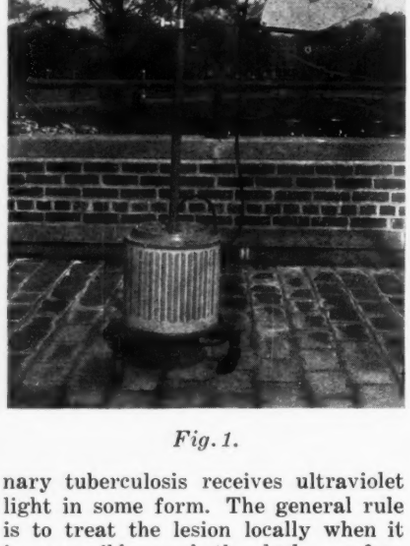

Fig. 1.

The sites of the lesions treated are, in the appropriate order of their occurrence, intestines, larynx, soft tissues of the chest wall (needle tract abscesses), pleura (empyema), middle ears, vertebrae, kidneys, perianal tissues, cervical nodes, bones other than vertebrae, peritoneum, tonsils and skin. Pleural effusions are not considered as indicating treatment unless they become purulent. All patients having had major surgery, such as thoracoplasty, receive irradiation as soon after an operation as possible.

An arbitrary division of cases has been made to facilitate group treatment. Those having intestinal tuberculosis receive mercury-vapor-quartz irradiation. All others receive carbon-arc irradiation.

Suberythema doses are used in all cases, the dose being determined by test exposure. The chest is covered in the case of acute pulmonary lesions.

General and localized exposures of the body surface of patients too ill to be moved are carried out at the bedside with a portable mercury-vapor-quartz lamp (Fig. 1). Patients who can be moved are treated in groups in rooms set aside for this purpose.

One room in the adults' building (Fig. 2) is equipped with eight mercury-vapor-quartz lamps. Each lamp is suspended over two cots and contains metal parabolic reflectors so arranged that two patients can receive generalized uniform irradiation simultaneously.

The burner-cot distance is adjustable between 44 and 60 inches. The average time required to produce a skin erythema on a brunette at 44 inches is five minutes. The lamps are equipped with hinged panes of quartz which can be used to filter out the more irritating rays below 2,800 Angstrom units (requiring about one-third more exposure time).

Each lamp contains a motor which automatically tilts the burner until it lights. The tilting can also be done by hand. Each group of ultraviolet lamps is accompanied by an infra-red lamp whose rays can be used to en-

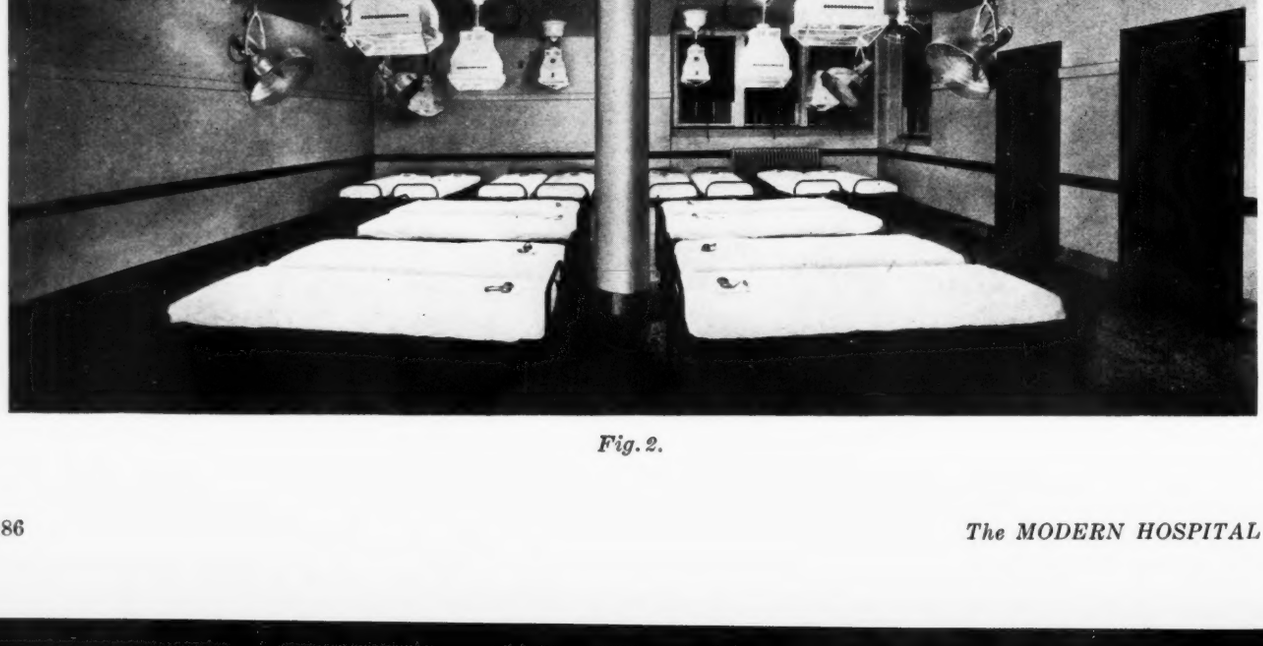

Fig. 2.

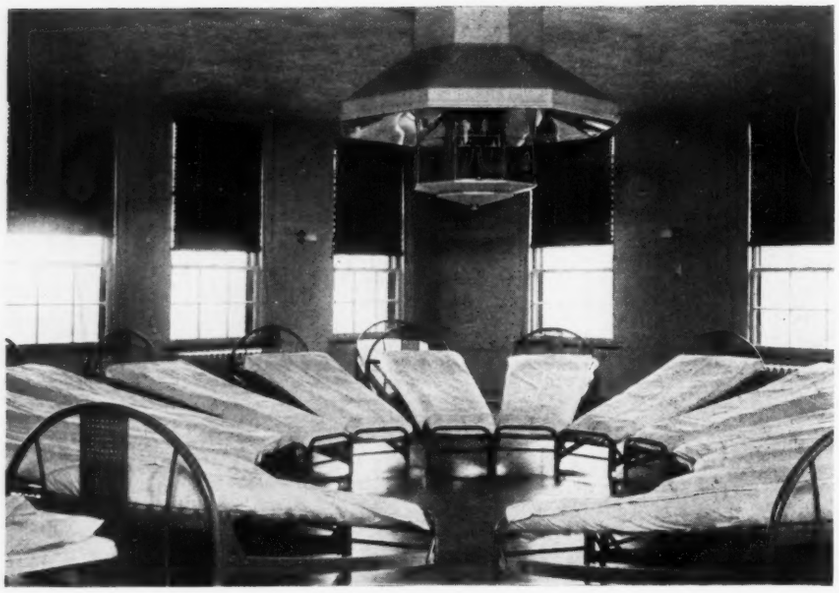

Fig. 3.

hance the effects of the ultraviolet rays. Four rotating fans having rheostats for speed control are placed so as to keep the air about the cots circulating gently. In addition, a suction fan ventilating system is in use. Wet and dry bulb thermometers indicate the room temperature and humidity. All lamps and fans are controlled from a small room separated from the treatment room by panels of amber colored glass.

A second room in the adults' building (Fig. 3) is equipped with a carbon-arc lamp which contains four units, each of which carries two pairs of carbons. The units are arranged in the lamp so that the rays from the arcs are distributed uniformly about the lamp. Reflectors direct the rays downward to the radially arranged cots which are tilted toward the lamp at an angle of 20 degrees.

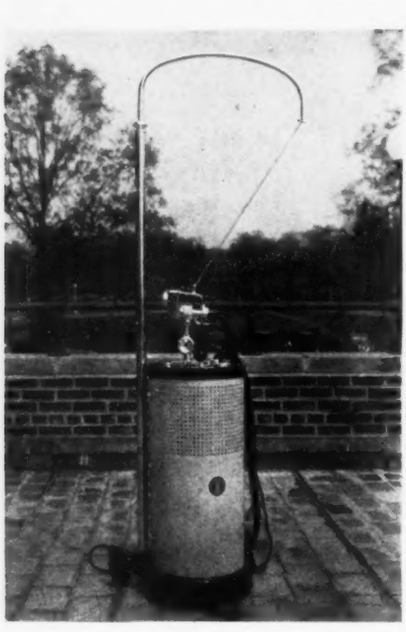

Fig. 4.

The foot of each cot is 6½ feet from the lamp. Irradiation is somewhat more intense over the part of the cot nearest the lamp. A skin erythema may be produced on a brunette in seven minutes. The lamp is enclosed by panels of quartz, which are removable, and act as filters. A suction fan in the ceiling above the arcs exhausts fumes and débris to the outside of the building.

The arc units and fan are individually operated from a control room similar to that described for the mercury-quartz room. The arc burns between only one pair of carbons in each unit at a time, the current being transferred automatically to the alternate pair every twenty minutes, thus prolonging the life of the carbons. Each pair will burn for eight hours. Metallic coated "C" carbons are used, and their feed is controlled automatically.

Ultraviolet rays are concentrated locally on accessible lesions by means of two portable lamps. A water cooled mercury-vapor-quartz lamp (Fig. 4) with suitable quartz applicators (Fig. 5) is used for treating sinus tracts, otitis media and lesions of skin and mucous membranes. A cold quartz lamp (Fig. 6) is available for the same purposes, but is used chiefly for the treatment of tuberculosis of the larynx, pharynx, mouth and nose.

Sun decks are available on all floors of the adults' and children's buildings for direct exposure to the sun's rays.

Children fall into two groups as regards phototherapy. Those who do not have acutely active pulmonary lesions receive general exposures to a carbon-arc lamp similar to the one already described. Natural heliotherapy is substituted on days when sunlight is adequate. Children who have acute pulmonary lesions do not receive phototherapy.

It is advisable to go thoroughly into the specifications and maintenance costs of each type of apparatus before installation. Burner replacements in mercury-arc lamps are the source of some expense. In general, mercury-arcs are considered more economical of electric current than the carbon-arcs. Carbon-arc lamps vary in maintenance expenses for new carbons. In a busy service carbons become a definite budget item and devices for economical burning of carbons such as described above, must be considered. The creation of air currents by fans is generally considered desirable. Adequate, independent, exhaust ventilation is a prime requisite.

Complete equipment of a twenty-cot "solarium" costs, depending upon the type of lamp and other equipment, from $2,500 to $4,500. Units should be so placed in the hospital building as to require the minimum of transportation of bed patients from rooms or wards. Conveyance of a group of twenty patients on beds or stretchers can disrupt even a generous elevator service.

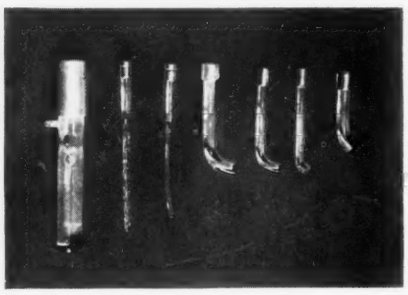

Fig. 5.

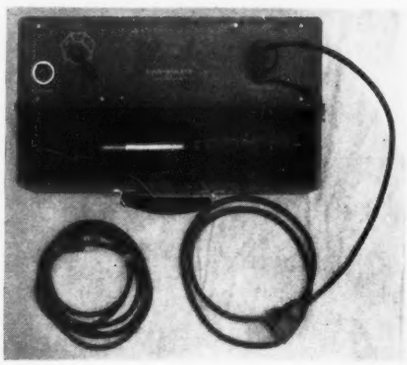

Fig. 6.

The phototherapy equipment described exemplifies the types of apparatus that are of value in the treatment of adults and children in institutions handling tuberculosis, orthopedics, pediatrics, and other groups for whom lamp therapy is prescribed. Portable lamps of the types shown will be needed, in addition, and in small services may be sufficient, without provision for treatment of large groups simultaneously.

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Dental Department Proves Its Value and Receipts Cover Cost

By W. M. Breitinger
Superintendent, Reading Hospital, Reading, Pa.

THE value of a dental department in a hospital is fourfold—it benefits the patient, the community, the physician and the hospital. The presence of such a department rounds out a complete medical unit. The immediate service of a dentist means more efficient treatment for hospital cases.

Twelve years ago through the kindness of an interested board member a complete dental equipment was contributed to Reading Hospital, Reading, Pa. At that time a staff department was formed from the practicing dentists in the community who contributed a few hours on various days of the week to conduct the department. In a short time it was discovered the great amount of dental work exceeded the amount of time busy practitioners could give to hospital work. Three years later we placed a dental intern on duty for one year's service. The following year we found the work growing so rapidly it was necessary to add the second chair and unit. Another one of the board members made this possible and at this same time we installed our own dental laboratory and secured a full-time dental resident and a dental intern.

We now have three chairs with a full-time resident, two interns and a hygienist, together with a part-time office assistant in attendance.

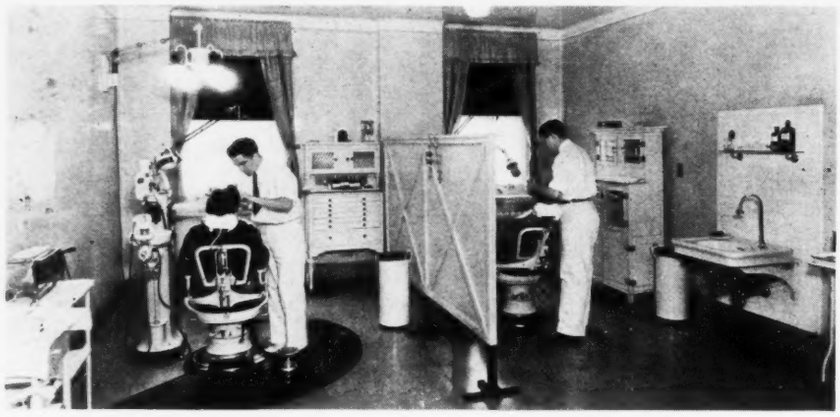
The dental resident supervises the department in addition to carrying on private practice at the hospital. All receipts, of course, go to the hospital. The department is now self-sustaining, as the receipts cover the entire maintenance cost.

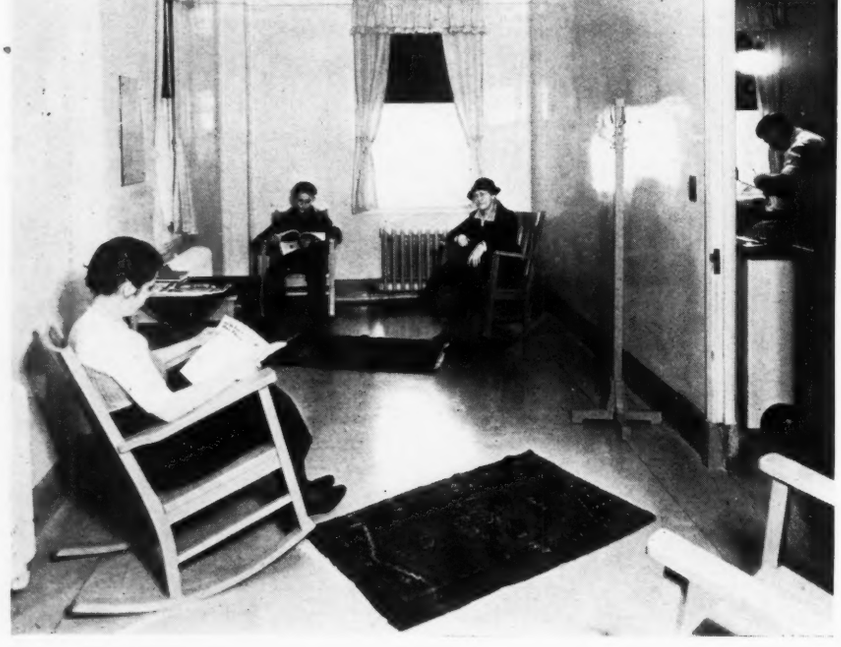
As is the rule with all out-patient clinics, only those are admitted as free or part-pay cases who are absolutely unable to afford private fees. These patients must bring notes of reference from their doctors, dentists, employers, relief or social agencies. Emergency treatment is given without this reference but investigation is made by the credit worker before a return visit.

The charges made for private in-patients' dental work are the same as those charged by the local dentists and the rates have been passed upon by the local dental society.

The cost of dental equipment ranges from $1,600 to $2,000 per unit, depending upon the style selected. This cost includes the chair, the operating unit with water heater and syringe, operating light, sterilizer with stand, instrument cabinet. The cost of running lines to the unit for waste, water, gas, air and electric current is an additional expense which necessarily varies according to location. Our own plant crew did this work and we estimate the cost to be about $150.

We also installed our own dental laboratory consisting of work bench units, vulcanizer, lathe, centrifugal casting machine and blow pipes, at an additional cost of $375.





The dental operating room at Reading Hospital has three chairs, with a full-time resident, two interns and a hygienist. The lower picture shows the waiting room for private patients who are awaiting service in the dental department.

Care of Cleaning Equipment

The life and usefulness of brooms, brushes, mops and various other items of cleaning paraphernalia may be greatly prolonged if a little care is exercised in the method in which they are put away when not in use. The indiscriminate piling of such equipment in a closet should be discouraged. Bristled articles should be hung by the handle to obviate the possibility of the tufted portion becoming flattened or lopsided from the weight. Mops should be wrung as dry as possible and hung in such a manner as to promote drying of the fabric. Noting the date of issuance of articles to employees with the express understanding that they are responsible for a reasonable length of service, has proved an effective method of assuring proper care.

FOOD SERVICE • • • •

Conducted by Anna E. Boller, Rush Medical College

A Smooth Running Food Service and How to Obtain It

By S. Margaret Gillam

Director, Department of Nutrition, New York Hospital, New York City

HOSPITAL food service has in the past been under the supervision of various persons, each being responsible for a specific activity, from the purchase of food until its consumption. Many times the old saying "too many cooks spoil the broth" could be aptly applied.

Unification of the food service department has gradually been taking place as administrators have been trained and could qualify for the responsibility. This latter type of organization with more centralized authority is in keeping with the best known principles of organization and it has contributed to more smooth running machinery for hospital food service.

However, organizations with varying degrees of centralization are not uncommon today and many of these are performing their duties satisfactorily. Because of years of working together each may dovetail into the food service at the proper moment but in a less experienced organization the results are not always gratifying.

Usually in the unified organization there are three distinct services — administrative, therapeutic and educational. In the small hospital one dietitian may perform all of these functions. In institutions requiring a larger staff it may be advisable to organize the staff into divisions according to the above functions, each division having the necessary officers and committees to carry on the work predicated to that unit.

The author holds that the food service department should be supervised by a professionally trained personnel and that the administrative, therapeutic and educational activities should be carefully unified.

Regular meetings or staff conferences of the groups should be held, with the head of the department present, and through her changes in policies may be presented to the administration or to other departments. It is desirable to have a conference room maintained for the use of the department. A combination of conference room and library is suggested if a nutrition library is not available elsewhere in the institution.

Facilities should be provided for offices for the staff either adjacent to the main kitchen or to the diet kitchen or space should be assigned on the floors for the dietitian whose major activity is concerned with the service to patients.

It perhaps is unnecessary to give the qualifications for members associated professionally with the department. However, for emphasis it is stated that the dietitian should meet the qualifications established for membership in the American Dietetic Association.

Qualifications of the personnel for various positions in the department should be set up and job specifications will be of assistance in classifying each position, since they are essential for efficient employment whether carried on within the unit or by a personnel department. They are also of assistance in giving the applicant a résumé of his activities.

The physical layout of the food department will depend upon many factors, such as size of the institution, the organization of the personnel, the type of patient cared for as well as the location of the hospital.[1]

Food service to patients in general may be by central service or by floor pantry service with the use of electrically heated food conveyors for bulk food transportation. In central service the trays originate in one unit and are carried by rapid transportation to the floor food stations. In this method the tray must be served as delivered unless a specific time has been prearranged for service. This system seems efficient if the number of trays is not too large.

The advantages are that personnel and equipment are concentrated in one unit and supervision is more satisfactory. Food is cooked as served with the post-stove time at a minimum. There is a minimum of leftovers which is not always possible when food is transported in conveyors to a number of units for service. There is less handling of food and appetizers and salads and desserts may be more attractively served. The special diets as well as all trays may have a wider range of foods than when too many individual items are transported for service at another point. In general there is more incentive for individuality of trays in central service.

Pantry Service Has Good Points

The advantages of central service become greatly minimized when the advantages of floor service are considered. There is less confusion with floor pantry service as the numbers served from each pantry are comparatively small. This activity may go on simultaneously throughout the hospital with the result that all patients regardless of the size of the institution may be served within a half-hour range. There is less distance for the tray to travel before reaching the patient, resulting in less concentration required to serve food at the optimum temperature.

Kitchens for this service are equipped so that special nurses may prepare individual items for patients and the equipment is available for serving patients during the day or at night. The system of service decided upon in an institution will always be a matter of individual preference.

The diet kitchen as a training unit for the student nurse and as a major production unit in dispensing hospital diets is fast disappearing. The value of this training is not great for the nurse, isolated as she is from her patient and with experience in quantity cookery not applicable later when she is on private duty or in an institution where there is usually a trained dietitian. The increase in the number of special diets also requires a more flexible type of organization.

In the newer method the menu is planned for patients with sufficient variation to make available the types of food required for all special diets in addition to the routine general, soft and liquid diets. The nurse receives her experience in planning special diets from the foods available and she rightly contacts her patient before she plans the diet. This method should be

[1]For a fuller discussion see "Planning Kitchens" by Herman Smith, M.D., Katherine Mitchell, and Ada Belle McCleery, THE HOSPITAL YEARBOOK, thirteenth edition, p. 55.

of value to her in a home where she plans the diet for her patient from the family menu.

This system necessitates a trained personnel on the floors serving and checking trays but eliminates an expensively equipped and staffed diet kitchen. Usually the main kitchen absorbs the preparation with little additional personnel. Floor food service under the supervision of a dietitian should result in more accurate ordering and accounting for food as well as control of ward pantry equipment and supplies. The dietitian having one activity to supervise for which she is especially trained will be able more easily to care for the food requirements and desires of individual patients and by being available to nurses and doctors she can contribute her knowledge to the service.

The advantage to a dietitian in knowing her patients and of being of constant assistance to them in giving instruction cannot be overemphasized. Teaching becomes a daily routine rather than a few hastily written instructions which the patient takes home and then does not understand.

Food service to personnel is usually considered more efficiently managed if concentrated. Here again the size of the institution is a deciding factor in arranging the layout. Centralization may be more efficiently supervised but there are other factors for consideration such as loss of time in waiting for service, increased noise and breakage and the necessity of quantity food production when little individual attention to personnel is possible.

Whether cafeteria or waitress service is used will depend upon the policy of the administration. The advantage given for cafeteria service is that it saves the time of personnel and gives them a wider selection of food. There is some belief that it raises food costs and increases food waste.

Whenever possible in an institution it is recommended that employees buy their meals instead of having the meals represent a part of their wages. This method puts a money value on food in the mind of the employee and dignifies the service. It has been noticed that under these conditions the meal hour becomes an hour of recreation and pleasure for employees.

The administrative functions closely associated with food service are menu planning, purchasing, storing, issuing and accounting as it relates to the cost of food, personnel and supplies.

Menu planning is extremely important to satisfactory food service. The types and number of menus will depend upon the layout to some extent. Here is a further value in decentralization of dining rooms as menus may be planned expressly for certain groups and the results are more satisfactory.

The purchasing of food may be centralized or the food department may act as an agent of the purchasing department in buying food commodities. Either method is successful and the key to its success in either case besides knowledge of buying is understanding and confidence.

Again the storing which is extremely important may be centralized in the food department or it may be an integral part of the hospital stores system. The important consideration is that adequate and proper storage be provided and storage refrigerators be sufficient to meet the needs of the institution for economical buying.

A perpetual inventory should be carried with the stock records showing a minimum and maximum carriage for supplies. Issuing should be by requisition only and the requisitions should be priced preferably before delivery of goods. A priced copy may then accompany the commodities, the duplicate being left in the unit to inform the person using the supplies of market prices.

Accounting Methods May Be Simple

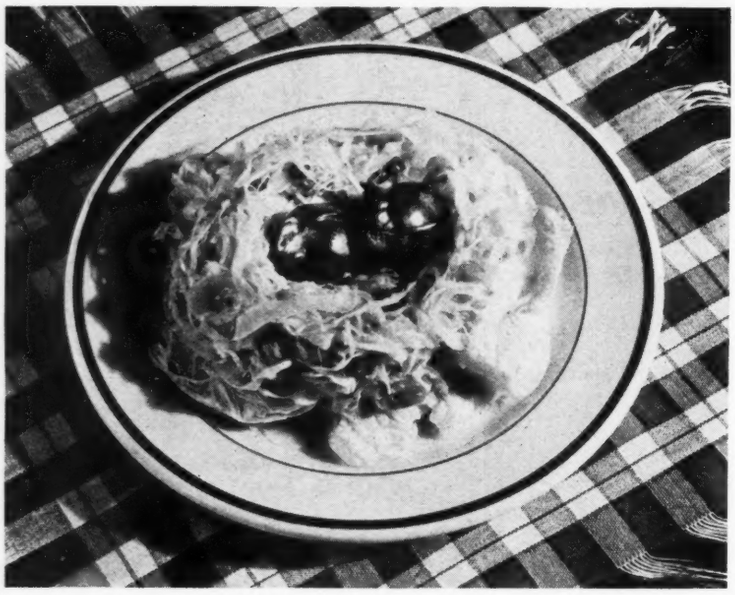
Accounting is most important in connection with a food service department. It may be a simple system or it may be detailed. The important factor is that a daily per capita cost of food be available. It should be easily understandable and the various details which make up the total cost should be available to those who control them. If the department operates on a budget, a procedure which is strongly recommended, daily over and under run should be recorded.

At the end of each month the costs should be reconciled with the purchases and the physical inventory, and adjustments made if necessary. The unit costs of supplies should also be known by the person originating the requisitions for stationery, cleaning supplies or replacement of equipment and again it is suggested that the duplicate priced requisition be left with the commodities.

The cost of personnel should be allocated to the units and if the institution operates on a budget, a system should

No. 16 — Bird's Nest Salad

By Arnold Shircliffe*



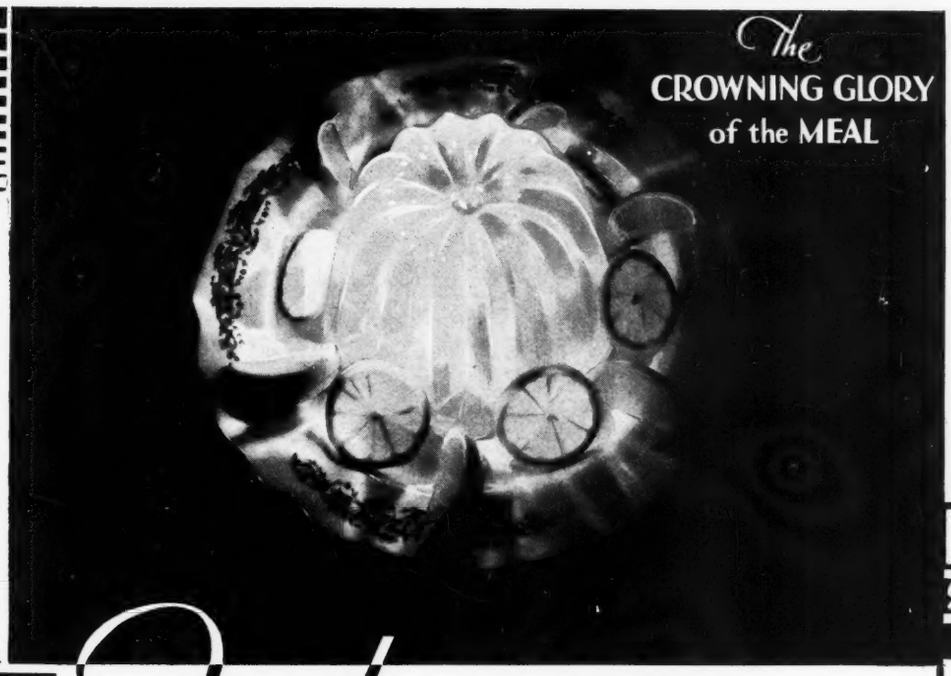
Lettuce
Coleslaw

Blue-Black Grapes
Cream Cheese

Water Cress or Parsley

ON A bed of lettuce, place a nest of finely shredded coleslaw. The finer the cabbage is shredded the more attractive is the nest. In the center of the nest place two large, blue-black grapes stuffed with cream cheese, or two egg-shaped molds of cream cheese which have previously been sprinkled with chopped cress or parsley. If desired, the cress or parsley can be worked into the molds of cream cheese, giving the eggs a mottled, greenish appearance. Serve with French dressing.

*Author of the Edgewater Beach Salad Book.



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One package makes 4 pints of the jelly.

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Analysis Knox Gelatine

Protein (14 amino acids)	85.0–86.0%
Calcium Phosphate	1.0–1.25%
Fat (less than)	0.1%
Moisture	13.0–14.0%
Carbohydrate	Nil

ACCEPTED AMERICAN MEDICAL ASSN. Committee on Foods

Of interest in the treatment of muscular dystrophy is the 25% glycine (aminoacetic acid) in Knox Gelatine.

Bacteriologically safe . . . pH almost neutral . . . odorless. Carbohydrate-free . . . exceeds in quality minimum U.S.P. standards.

be installed for control. One of the simplest systems within the department is the use of a card system. Each position is set up on a colored budget card giving the details of the position as provided in the yearly budget, with all positions listed by units. In addition on this card may be recorded information as to the date and name of the employee each time the position is filled and the date the employee was released or resigned, including the reason.

In front of this card is a white card which is an employee's record card. This gives the details of transfers, promotions, physical examination, illness and vacation with the visible information of pay roll number, name, position, wage rate and type of maintenance if any. In addition there should be a ledger giving the analysis of the monthly, bimonthly or weekly pay roll according to the classification of units as set up by the department for control. The ledger should also contain such information as the daily census by units; the weekly cost of stationery and supplies, the cash receipts and credits for food sold and the monthly totals for the department by units.

Monthly Summary Needed

A monthly report should summarize all charges to the food department as a whole and by units, giving the food cost, the direct and indirect pay roll, the cost of supplies, cash receipts or credits, profit or loss if indicated. It should include the additional charges allocated to the food department and beyond its control, such as engineering, housekeeping, laundry and general administrative overhead.

For unit budgetary control at the end of each month all information may be transposed on unit yearly budget sheets. Monthly expenses of all kinds as well as income, profit and loss are accumulated from month to month indicating the trend during the year and giving complete accumulative information to date for the expenditures as well as for the budget.

Inventories are important in a food department for control. Complete daily food inventories are excellent for control of supplies. Meal to meal inventories of leftovers result in added economy. Equipment inventories should be set up in all units with proper description of items and a standard quantity indicated on the basis of operation. Monthly inventories should be taken and, as advisable, the equipment replaced to meet the standard. This is an excellent method of familiarizing personnel with their equipment and emphasizing their responsibility in its care and control.

The educational opportunities presented in a food department in a hospital will depend upon the type of institution and its interest in education. The in-patient teaching has been discussed. The out-patients who require instruction in diet may be best served when there is a food clinic in connection with the hospital. This should be easily accessible from the out-patient clinics. There should be sufficient space for a waiting room, and offices for interviewing and instructing patients individually. Provisions should be made for quick transfer of patient records. The food clinic in some institutions is important in its relationship to community nutrition work giving assistance to welfare and relief agencies.

Food Clinic Important

The food clinic makes an excellent laboratory for the nurse, the student dietitian and the medical student, for observation and practice in the method of instruction given when the patient must care for his own diet in his home. Classes and talks on food are often provided for mothers while in the hospital. Classes demonstrating formula preparation are helpful to the mothers and group teaching stimulates interest through discussion. Prenatal clinics afford opportunities to the dietitian and nurse to assist mothers in their food problems.

The food department especially in a teaching hospital has an important rôle in giving experience to student nurses, student dietitians and medical students. Student nurses should be given as much time as can be provided in their curriculum for study and observation of diet in relation to patients. As previously suggested it seems best to have the nurse secure the greater part of her training while working on the floors in close proximity to the patients. Frequent conferences with the instructor, directed study, reading and discussion of the diseases for which she is providing diets and serving trays make her work more understandable.

There is even better correlation if the nurse is able to care for the patients for whom she is writing diets and serving trays as is the case in some of our nursing schools. Medical students after a series of lectures on nutrition and diet in disease should be given the opportunity for study and observation in the food department. The hospitals are meeting the standards for training dietitians in a commendable way and future dietitians will have received the benefits from the high standards set forth by the national association for the approval of student dietitian courses.

The range of activities in the dietetic department is varied and successful management requires an interest that does not flag but covers the whole range, keeps in mind the coordination of the activities within the department and lends cooperation to other departments.

FOOD FOR THOUGHT

• The highly praised but much despised spinach is slipping, and may fall from its pedestal, according to Dr. E. B. Hart, University of Wisconsin. This will gladden the hearts of those who have been conscientiously pushing spinach into their menus in some form or other. Doctor Hart has done some interesting work on the availability of the iron in various common foods. A new table, showing the average serving of certain foods, the amount of iron present, and the amount available, gives some rather surprising results.

• Glancing over a recent report from Washington, we find that meat prices have jumped from 17 to 55 per cent during the last year. The public has resented the increase, not realizing that government control of livestock and later the drought have limited the supply of meat and have forced prices up rapidly. However, there was no time during the past year that prices have equalled those of 1930, which, according to Secretary Wallace, were 18 per cent higher than they are now. Those who have felt it necessary to omit meat from some of their menus because of the price, will be glad to know that in the last two months, the prices have dropped, in some cases as much as 15 per cent.

• To the many dietitians to whom garbage disposal has been more or less of a problem, it will be rather a shock to learn that they can now just dump the food waste into the kitchen sink! An electrical device makes this possible by reducing the waste foods to a fine pulp which washes down into the sewer without danger of clogging. The claim is made that the device will dispose of all kinds of food, grease and oily substances, and even soup bones, without stopping up the drain —the only exception being tin cans and bottles. And best of all, the expense of operating such a piece of equipment is negligible. At present only small sizes suitable for diet kitchens are available.

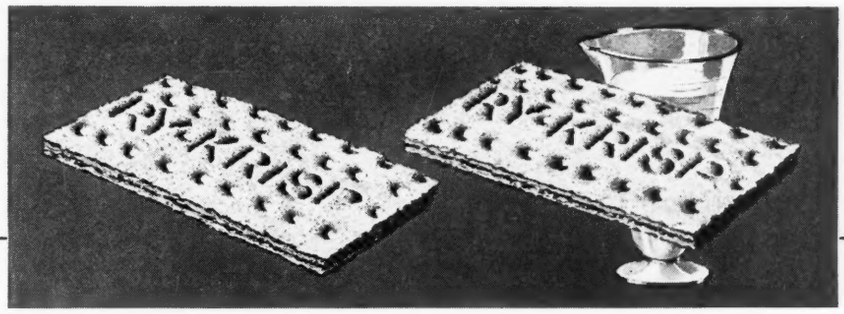
• The diet manual of the University of Michigan Hospital has come out in the form of a small book. Anyone familiar with the old manual will be interested in this because of its practical and attractive set-up.

• An interesting booklet, "Low Cost Quantity Diets," was published a few months ago by the administration section of the American Dietetic Association. The recipes give ingredients necessary for 50, 100 and 200 servings. All dietitians who are trying to keep down food costs (and who are not?) will appreciate having a copy of this booklet, which may be obtained from the office of the association for 35 cents.

Why RY-KRISP

helps to correct common constipation

—*naturally*



A high percentage of bran. High pentosan and crude fibre content.

Each Ry-Krisp wafer is capable of absorbing five times its own weight in water.

COMMON constipation, due to insufficient bulk, frequently responds quickly and surely to Ry-Krisp introduced into the patient's normal diet.

Made simply of whole rye, salt and water, double baked to tempting crispness, Ry-Krisp is a wholesome food for children and adults. Its bran, pentosan and crude fibre content all tend to produce normal bowel action, while its low water content (only 6.8%) and porous structure permit each wafer to absorb five times its own weight in water—producing needed bulk to stimulate natural peristaltic action.

Easy to use, and crisply delicious, Ry-Krisp fits into the menu naturally and pleasantly. Served as toast at breakfast, with soups, salads or main courses at other meals it contributes unique flavor and welcome variety. In fact, these wafers taste so good with almost *any* food that the patient is glad to eat them regularly. This, of course, insures more satisfactory results.

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Modern Dress Provides Tray Appeal

By Juanita Trapp

Head Dietitian, Orange Memorial Hospital, Orange, N. J.

THE arrival of the food tray, whether in the private rooms or in the wards, is a significant and critical event, both for the patient and for the hospital. At this time, when the natural craving of an individual for a good meal is either satisfied or denied, comes our big opportunity to stimulate appetite by tray appeal.

The battle may be won or lost at the first glance. While first impressions may be inaccurate, they are of the utmost importance at such a time, and every effort should be made to produce an effect likely to arouse the interest and anticipation of the invalid in the food set before him.

Tray appeal is not confined to cleanliness, essential as such an attribute unquestionably is, nor does it rest with any precise arrangement of silverware or dishes. It is a happy combination of a number of details which while insignificant in themselves form in the aggregate a pleasing setting for the food service. Most important of all perhaps, it must be motivated by vision, by a creative instinct inspired by the desire to achieve results through different channels, coupled with a close acquaintance with trends in modern equipment.

Tray appeal has been enhanced materially of late through modern dress. Silverware, for example, assumes new beauty through simplification in pattern and form in keeping with the streamline age in which we live. China has gone radical to the extent of abolishing the old-time wide rim and substituting in its place a far neater narrow edge which is also a space saver. Glassware no longer has that institutional look. It appears daintily fragile yet possesses a serviceability truly astounding. Everywhere color is rampant, affording no end of happy combinations limited only by the size of the budget.

Attention first should be given to the tray itself. A primary requisite is that it shall not appear overcrowded. For this reason, it should be no smaller than 22 by 16 inches. A wide variety is available from which such selection may be made as seems best adapted to the specific requirements.

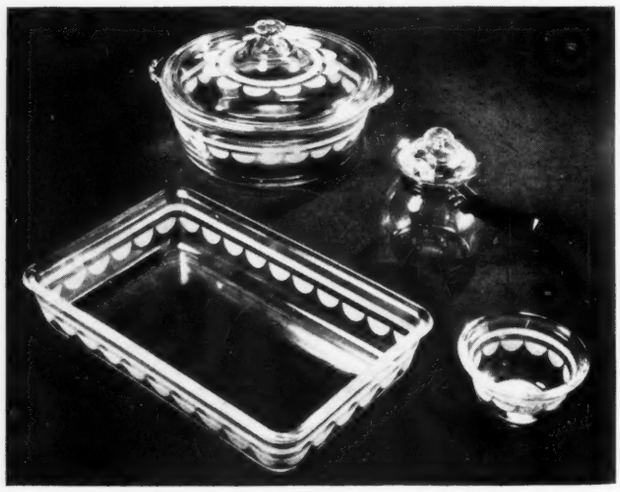
Speaking generally, there is much to be said of both metal and composition types. The metal tray withstands well the application of extreme heat used in sterilization. It also can take hard knocks and not crack under the strain. The composition tray on the other hand is quiet, light in weight and may be purchased in colors. It is also free from other bad features, such as soiling the hands or the linen.

The well dressed tray today wears linen, immaculately fresh for each meal, as a suitable background for sparkling silver, china and glassware. A pleasant change is afforded by the use of colored linen in pastel shades to harmonize with the china. Better to face facts now than when it is too late, however, and it must be admitted that to use colored linen is impractical because constant laundering fades the fabric. One other note — the well dressed tray and the napkin ring have parted company forever.

The use of paper covers and napkins in private room service is generally regarded as inappropriate. In the ward service, however, where greater economy must be practiced, a fresh paper napkin and tray cover with each meal seems far superior to linen which must be used throughout the day. A great variety of patterns are available, many of which are accurate reproductions of the finer designs of linen.

There is almost no limit to what the dietitian can do with paper napkins and tray covers for special occasions. At such times they are gladly received in every part of the hospital, from the nursery to the most elaborate private suite. Christmas, Thanksgiving, Fourth of July, to say nothing of birthdays, offer all manner of opportunities for introducing tray appeal.

Patterns innumerable are available for just such events, a joy to the heart of child and grown-up alike, and despite the additional burdens they inflict, who can resist the temptation



China has gone radical to the extent of abolishing the old-time wide rim and substituting a narrow edge, which saves space. Glassware no longer has an institutional look but is dainty in appearance as well as practical. The illustration shows samples of decorated glassware.

When Under-Nutrition *Calls for Calories prescribe*

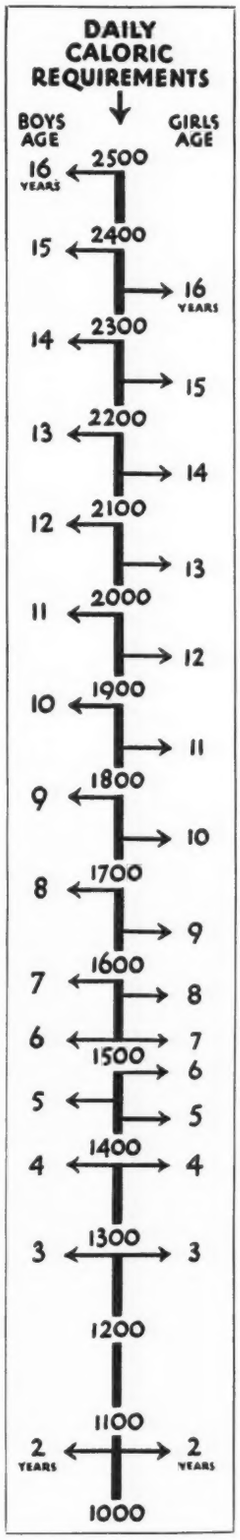
The child's failure to gain in weight is the bête noire of every doctor. If the total caloric intake exceeds the output, the child will gain weight, provided the diet is adequate and chronic disturbances corrected. High caloric feeding is simplified by reinforcing food with Karo Syrup. Low caloric output is facilitated by providing rest periods. This energy-balance may be neglected in older children in the enthusiasm for vitamins and minerals, neither of which alone adds to the caloric requirements.

Every article of the diet can be enriched with calories. And Karo is a carbohydrate of choice. A tablespoon of Karo provides about sixty calories and one *fluid* ounce about one hundred twenty calories.

Karo is relished added to milk, fruit and fruit juices, vegetables and vegetable waters, cereals and breads, and desserts. Karo is well tolerated, readily digested and effectively utilized...Karo does not cloy the appetite, produce fermentation or disturb digestion.

Karo Syrup is essentially Dextrins, Maltose and Dextrose, with a small percentage of Sucrose added for flavor.

Corn Products Consulting Service for Physicians is available for further clinical information regarding Karo. Please Address: Corn Products Sales Company, Dept. H-11, 17 Battery Place, New York City



Figures from Kugelmass's "Feeding in Infancy and Childhood"

to provide these extra touches? If the budget permits it, daintily flowered tray covers and napkins lend a seasonal touch to summer tea trays. The cost is not great and the result is sure to be appreciated.

No matter what the season may be, desserts are made more appetizing served with a lace paper doily beneath. It should always be remembered that it is the little things that count.

Now we come to a major item — silverware. Simplicity is the predom-

When a silver hot water plate is used the hot meal reaches the patient at the right temperature.

inating characteristic today. Flatware reveals itself in a new platinum finish which minimizes scratching and makes cleaning comparatively simple. Plain, conventional patterns, either English or Colonial in feeling, are especially recommended. Nothing lends more allure to the hospital tray than well selected and carefully cared for silver. Its durability, too, assures economy in the final analysis and a little care in handling and cleaning will go far in eliminating the danger of dents and scratches.

Many different articles are available, depending solely upon the size of the budget. Some items are of course to be regarded as essentials.

What can give a dietitian greater satisfaction than the knowledge that each hot meal reaches the patient at the same temperature at which it left the kitchen? The silver hot plate is the proper answer, of course. It likewise provides the tray with an added touch of distinction.

For special consideration is the new type of silver tea and coffee pots with lips in place of the more familiar spouts and extra strong hinges which offer greater support to the top and are far neater in appearance.

At this point, acquaintance must be made with what a leading manufacturer chooses to term his four-in-one bowl. First, this appears as an excellent receptacle for a half grapefruit, orange or baked apple. Presto, change! and it makes its second appearance serving cereals or broths. A cover enables hot dishes to be carried some distance and still remain hot. Next, a collar slipped over the top provides an opening of just the right size for a glass of orange juice, tomato juice or some similar appetizer. Another collar holds a glass liner for serving ice creams, ices or sea foods.

Among the essentials which a modern tray can scarcely do without is the silver toast cover. This particular item is too familiar to need description. It is mentioned merely as a reminder that an adequate supply should be available at all times.

The days of white china will soon be as remote as those of white hospital walls. That is, if the present trend toward backgrounds of shades ranging from ivory to tan continues. Single banded china is being replaced by decorative floral designs which are gay and colorful.

Practical as Well as Pretty

Here the modern note is again in evidence, particularly noticeable in the new cubical tea and coffee pots of heavy pottery which now can be obtained with creamers and sugar bowls of the same modernistic pattern. In addition to being attractive and colorful, these are most practical, since they are convenient for the patient to handle. They have built-in spouts, greatly reducing the possibility of breakage. These are available in almost any of the pastel or spring color shades.

Patients are no longer obliged to muster what remaining strength they possess to lift a china cup to their lips. What a relief, too, is the lighter weight china to nurses and attendants who must carry trays any distance! It has been proved also that lighter weight is possible at no sacrifice of practicability.

Overcrowding is something to be studiously avoided. That is why the new narrow rim china has won so many adherents in the comparatively short time it has been on the market. Another precaution that may be taken against overcrowding is to buy the size of each article that will most satisfactorily fit the tray dimensions. A point in question is the soup container. Soup cups are preferable to bowls since they require less space and used with covers they retain the heat efficiently.

The number of china items can also be conserved by using the bread and butter plate and the salad plate for the same purpose, also the breakfast and tea plate. Egg cups can be procured which are equally well adapted to serving stewed fruits, puddings and the like.

Another step in overcoming ugly serviceability has been to eliminate the old, unwieldy heavy duty tumbler and substitute in its place far daintier safe-edge glassware. A cylindrical design with a bulge near the top reduces breakage in washing.

Glass May Give Color Note

These new glasses are obtainable in colors, and pleasing combinations on the trays can be effected in shades harmonizing or contrasting with the china. If the budget permits, colored glassware is especially attractive on supper trays. In serving desserts particularly, such as puddings and stewed fruits, the appearance of the food is enhanced many times by using glass sherbet dishes, either plain or colored.

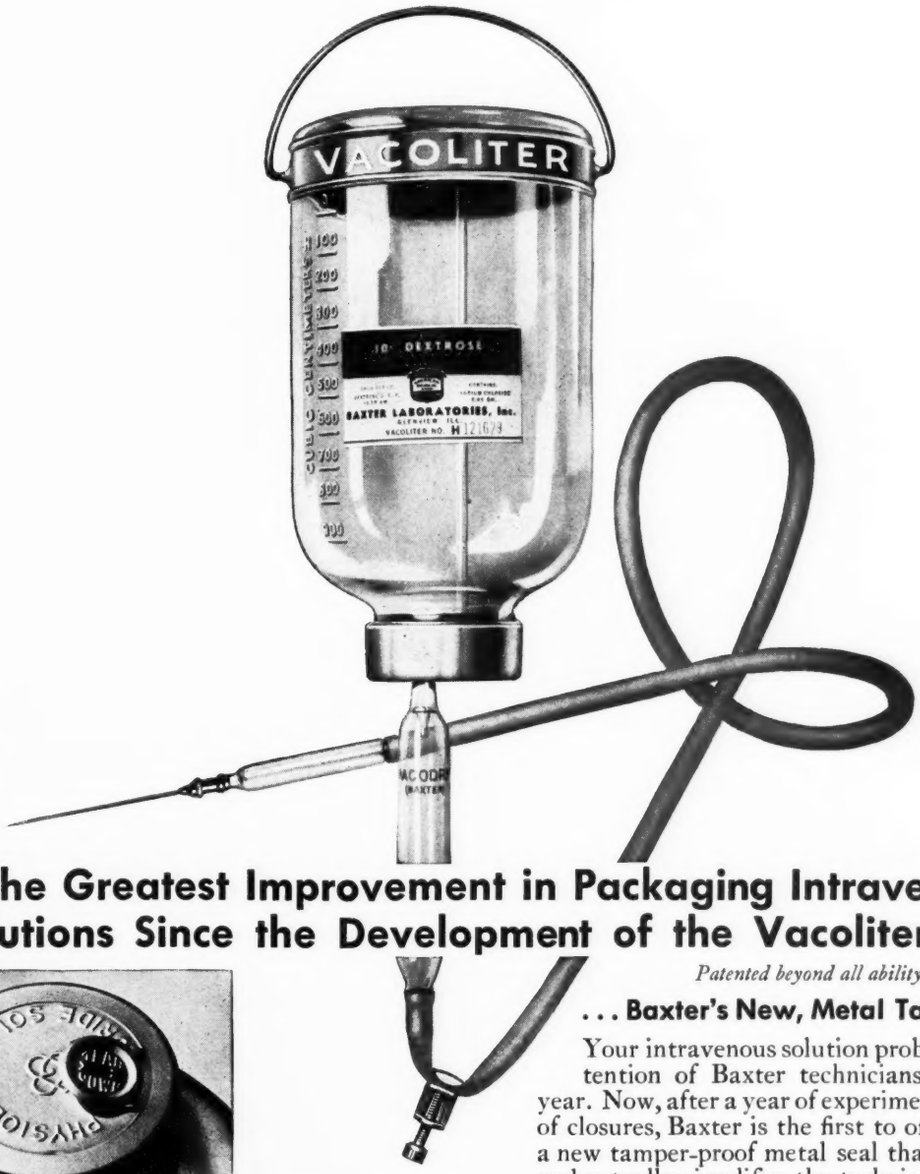
Even cooking glassware has assumed new importance of late. To its utilitarian characteristics, which need no endorsement, has now been added style appeal in the form of etched patterns. Thus, custards and junkets may be served to the patient very daintily in the same cups in which they have been made.

Important as is modern equipment in providing tray appeal, an active imagination on the part of the dietitian is equally essential in achieving a setting that will satisfy the fanciful whims of the sickroom critic. Inex-

Simplicity of design features today's silverware.

pensive "extras" go a long way in furnishing a personal touch that makes each patient feel that the tray has been prepared for his exclusive benefit.

Holidays and birthdays afford an opportunity for carrying out this idea and patients appreciate the fact that such occasions can be observed and celebrated in a small way even though one is bedridden. At the Orange Memorial Hospital, Orange, N. J., a system has been arranged whereby birth dates are forwarded to the dietary department and patients whose length of stay has been two weeks or more are remembered with a small birthday cake and card. The satisfaction derived by the patient from these small favors more than compensates the dietitian for the effort she has made. Even more important, it builds good will for the institution.



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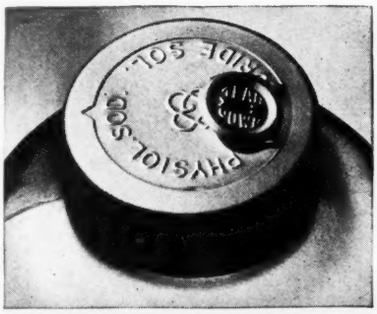
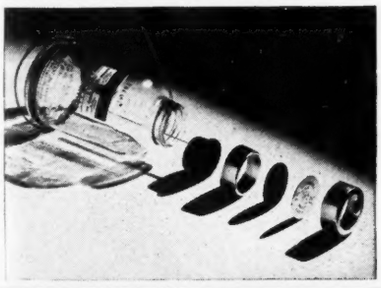


Unretouched photograph showing Baxter's new tamper-proof, metal seal.



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December Dinner Menus for the Staff*

By Lillian B. Corothers

Chief Dietitian, Evanston Hospital, Evanston, Ill.

Day	Appetizer or Soup	Meat, Fish or Substitute	Potatoes	Vegetable	Salad or Relish	Dessert
1.	Beef Bouillon	Chicken à la Maryland	Mashed Potatoes	Buttered Cauliflower	Fresh Fruit Salad, Radishes and Olives	Rum Bisque Ice Cream
2.	La Petite Marmite	Broiled Lamb Chops	Parsley Butter Potatoes	Buttered Asparagus	Banana and Nut Salad	Gelatin With Whipped Cream
3.	Tomato Juice Cocktail	Baked Ham, Raisin Sauce	Candied Sweet Potatoes	Buttered Green Beans	Grape, Marshmallow and Pineapple Salad	Chocolate Blancmange With Whipped Cream
4.	Oxtail Soup	Chicken Shortcake	Parsley Butter Potatoes	Mashed Squash	Head Lettuce, Roquefort Dressing	Three-in-One Ice
5.	Pea Purée	Broiled Tenderloin Steak	Mashed Potatoes	Julienne Carrots	Orange Salad	Grapenut Custard
6.	Creole Soup	Broiled Lake Trout, Parsley Butter Sauce	Escalloped Potatoes	Harvard Beets	Jellied Fruit Salad	Prune Whip, Custard Sauce
7.	Vermicelli Soup	Swiss Liver	Mashed Potatoes	Stewed Tomatoes	Waldorf Salad	Fruit Cup
8.	Consommé	Roast Chicken With Dressing	Tea Room Potatoes	Buttered New Peas	Jellied Gingerale Salad, Celery and Olives	Banana Ice Cream
9.	Lima Bean Purée	Prime Ribs of Beef	Creamed Potatoes	Buttered Carrots	Tomato Salad	Orange Ambrosia
10.	Vegetable Soup	Baked Ham, Mustard Sauce	Mashed Sweet Potatoes	Buttered Spinach	Head Lettuce, French Dressing	Gelatin Whip
11.	Beef Okra Soup	Broiled Tenderloin Steak	Parsley Butter Potatoes	Mashed Rutabagas	Spiced Apple Salad	Lemon Milk Sherbet With Wafers
12.	Noodle Soup	Roast Leg of Lamb, Mint Sauce	Browned Potatoes	Creamed Celery	Fresh Fruit Salad	Spice Cup Cake
13.	Tomato L'Anglaise	Broiled Salmon, Butter Sauce	Escalloped Potatoes	Buttered Brussel Sprouts	Perfection Salad	Chocolate Bavarian Cream
14.	Pea Purée	Meat Loaf, Creole Sauce	Parsley Butter Potatoes	Buttered Broccoli	Head Lettuce, Roquefort Dressing	Baked Apple
15.	Alphabet Soup	Chicken à la Maryland	Mashed Potatoes	Buttered New Peas	Cooked Vegetable Salad, Celery and Radishes	Tutti-Frutti Sundae
16.	Scotch Broth	Broiled Lamb Chops	Parsley Butter Potatoes	Buttered Carrots	Tomato Salad	Blueberry Cobbler
17.	Mulligatawny Soup	Roast Leg of Veal	Mashed Potatoes	Baked Acorn Squash	Fresh Fruit Salad	Charlotte Russe
18.	Tomato-Rice Soup	Calves' Liver and Bacon	Escalloped Potatoes	Buttered Broccoli	Waldorf Salad	Pineapple Ice With Wafers
19.	Vegetable Soup	Chicken Fricassée	Mashed Potatoes	Buttered New Peas	Coleslaw	Fruit Cup
20.	Noodle Soup	Broiled Halibut	Creamed Potatoes	Stewed Corn	Tomato Aspic Salad	Peach Betty, Lemon Sauce
21.	La Petite Marmite	Baked Ham, Raisin Sauce	Mashed Sweet Potatoes	Buttered Spinach	Combination Salad, Celery and Radishes	Heavenly Hash
22.	Consommé	Broiled Chicken	Creamed New Potatoes	Buttered Brussel Sprouts	Fruit Salad	Chocolate Sundae
23.	Fruit Cocktail	Swiss Steaks	Parsley Butter Potatoes	Mashed Rutabagas	Head Lettuce, French Dressing	Lemon Snow, Custard Sauce
24.	Pea Purée	Prime Ribs of Beef	Mashed Potatoes	Baked Acorn Squash	Fresh Fruit Salad	Orange Ice
25.	Beef Bouillon	Roast Turkey With Dressing, Giblet Gravy	Mashed Sweet Potatoes	Buttered New Peas	Jellied Cranberry Salad, Celery, Radishes, Olives	Xmas Pudding
26.	Consommé à la Royale	Roast Leg of Lamb, Mint Sauce	Parsley Butter Potatoes	Buttered Cauliflower	Tomato Salad	Baked Custard
27.	Alphabet Soup	Broiled Lake Trout	Tea Room Potatoes	Stewed Tomatoes	Head Lettuce, Thousand Island Dressing	Fruit Gelatin With Whipped Cream
28.	Vegetable Soup	Veal Cutlet, Pimiento Sauce	Parsley Butter Potatoes	Buttered Brussel Sprouts	Combination Salad	Orange Ambrosia
29.	Tomato Bouillon	Braised Chicken	Mashed Potatoes	Creamed Spinach	Jellied Cucumber and Pineapple Salad	Strawberry Ice Cream
30.	Chicken-Rice Soup	Lamb Fricassée	Parsley Butter Potatoes	Buttered Peas and Carrots	Stuffed Prune With Cottage Cheese Salad	Apple Betty, Lemon Sauce
31.	Tomato Juice Cocktail	Roast Beef	Mashed Potatoes	Buttered Green Beans	Grapefruit and Apple Salad	Caramel Spanish Cream

*Recipes for any of the foregoing dishes will be supplied on request by Anna E. Boller, The MODERN HOSPITAL, Chicago.

NEWS IN REVIEW • • • •

Nationwide Health Survey Under Federal Auspices to Include Study of Hospitals

A study of the hospitals of the country with especial emphasis on the extent to which different types of institutions serve their communities is included in the nationwide public health survey now being undertaken by the U. S. Public Health Service, according to a recent report from that organization.

Since the internal administration of hospitals, it is stated, has been studied in some detail, the present investigation was designed to secure information covering such items as services and facilities available, the territorial origin of patients, diagnosis, type of treatment and the question as to who defrays the cost of treatment.

The extensive program of public health study, of which the hospital survey is only one phase, is being conducted as a federal project under the WPA. A commissioned officer of the U. S. Public Health Service is in general charge of the hospital investigation. A schedule is to be completed by "white collar" relief workers for representative hospitals in the general study areas after which the coding and tabulating of information gathered will be performed as a part of the general inventory study. The final report will be prepared under the direction of the officer in charge of this particular phase of the survey.

Other features of the general public health inventory include a house to house canvass in the cities and rural districts of nineteen specified states seeking information regarding disabling illnesses, the extent of disability from them, and the nature of chronic diseases and impairments.

In all states of the country through various other means of inquiry, data are to be obtained regarding public health and medical facilities, the extent to which they are used in different types of communities, in different income groups and by persons suffering from various kinds of chronic diseases. Determination of sickness and mortality rates according to occupation, based on records of sick benefit associations will be made, and a special survey is being undertaken to determine the incidence of communicable disease, the frequency of immunization, and the completeness of reports to health departments.

The survey began in October and it is expected that the field work will continue until the last of March or April, 1936.

New York Starts Drive for $2,000,000 Hospital Fund

In the face of an estimated deficit of $4,894,000 for New York City's $200,000,000 voluntary hospital system, the United Hospital Fund is undertaking a campaign under the leadership of Gates W. McGarrah, banker, to raise a minimum fund of $2,000,000 this fall to aid in combating the situation.

Mr. McGarrah states that the situation has become a community crisis. The overcrowding of the twenty-six municipal hospitals which care for the destitute has created dangerous and uncomfortable conditions for patients. On the other hand, the 114 voluntary hospitals which serve all classes of people have hundreds of vacant beds because the institutions lack the money to operate them.

Although drastic economies are being practiced, the point has now been reached where further curtailment would be at the cost of human suffering, Mr. McGarrah states in a report on the situation. Only 25 per cent of the 440,000 bed patients cared for in hospitals each year pay the entire cost of their hospitalization, it is reported.

California Lawsuit Deals With the Nonindigent

An important lawsuit now being heard in the district court of appeals of California will determine the legal right of county hospitals in California to accept nonindigent patients when little effort is made to collect fees from them.

The suit is being pressed by the California Medical Association against the board of supervisors of Kern County. A brief has also been filed by the Association of California Hospitals as *amici curiae* in support of the plaintiffs.

In its brief the Association of California Hospitals contends that the legislature has not conferred power upon the county board to accept nonindigent patients and that a fair construction of the statutes demands the conclusion that the general laws of the state deny such power.

The brief holds that the previous court decisions in California deny the power and that the state constitution does not confer it. The state legislature would be barred from conferring such power, the brief declares, because free hospitalization to private citizens, except those with certain ailments, would be a gift of public money and the taxation used to raise this money would be for a private and not a public purpose.

Peacetime Veterans Eligible for Care

Peacetime veterans will be eligible for hospital care under the new Harrison Hospital Law recently signed by President Roosevelt. Veterans' Administrator Frank T. Hines has explained in a statement that the new law affects a group of peacetime veterans who hitherto had been barred from hospital care. He said those suffering from service connected disabilities or from permanent disabilities, tuberculosis or neuropsychiatric ailments, even if they were not service connected, would be eligible for hospital care.

Family Hospital Protection Offered at Lower Cost

A "Family Plan" for providing hospital care at less than established rates has been announced by the Cleveland Hospital Service Association as now under operation in that city. The plan, in general, provides that members of the family of employed subscribers may be enrolled in the association and receive a 50 per cent discount from the established charges of the hospital to which they are taken, for a period of twenty-one days.

For this protection, the association charges one-half the premium regularly charged to the employed subscriber. Under the plan, those who desire semiprivate accommodations, pay $4.50 a year, and those desiring ward service pay $3.60 a year. Payments may be made semiannually or annually.

A family member is defined as father, mother, husband or wife, unmarried children or unmarried brothers and sisters living at the same address. Family members covered are presumably unemployed, and an individual fee is paid for each member of the family subscribing.

The association states that after thirteen months of operation, they now have 13,000 contracts in force among employed groups.

Canadian Hospital Council Holds Successful Meeting at Ottawa

The Canadian Hospital Council held its third biennial meeting in Ottawa, Ont., October 8, 9 and 10.

Delegates included representatives from all of the twelve hospital associations in Canada, from the federal government, six of the provincial governments and the Canadian Medical Association. Also present were many unofficial representatives from a large number of other organizations.

Among the subjects discussed were "The Problems of Small Hospitals" under the leadership of Rev. H. G. Wright, Inverness, N. S.; "A Comparative Analysis of Hospital Legislation in the Various Provinces" by W. R. Chenoweth, Montreal; "The Relationship of Canadian Hospitals to the British Preferential Tariff and the Empire Trade Treaties" by Dr. A. F. Anderson, Edmonton; "The Rôle of Private Hospitals and Their Oversight by the State" by Dr. B. T. McGhie, deputy minister of health for Ontario; "The Development of Community Interest" by Rev. H. Bourque, S.J., St. Boniface, Man.; "Medical Problems in Hospital Administration" by Dr. S. R. D. Hewitt, St. John, N. B.; "The Certification of Specialists" by Dr. A. K. Haywood, Vancouver; "Trends in Construction and Equipment" by Dr. A. L. C. Gilday, Montreal; "The Participation of Hospitals in Health Activities" by James H. McVety, Vancouver; "Convalescent Hospitals," by Dr. Harvey Agnew, Toronto; "Problems of Administration" by Dr. George F. Stephens, Winnipeg; "Nursing Developments in Canada" by Rev. Mother Audet, Campbellton, N. B., and "Statistical Studies of Hospital Data" by James C. Brady, chief of the department of institutional statistics, Dominion Bureau of Statistics.

Insurance Problems Discussed

Unemployment insurance, which is shortly to come into effect in Canada, was thoroughly discussed and the exemption of hospitals from its provisions was requested. Recent legislation with respect to traffic accidents was reviewed by Dr. L. A. Lessard, of the Quebec Bureau of Public Charities. An excellent review of "Scientific Methods of Collections" was given by the chairman of a special committee, Leonard Shaw, Saskatoon, Sask. Health insurance received considerable discussion, and recent legislation was reviewed by Dr. A. S. Lamb, inspector of hospitals for British Columbia, and by Dr. E. A. Archer of Lamonte, Alta.

An excellent study of "Tuberculosis in Nurses" was presented by a special committee under the direction of Dr. R. T. Washburn, Edmonton, and Dr. R. J. Collins, St. John. Dr. D. M. Robertson, Ottawa, reviewed the recent international hospital association meeting in Rome.

One of the most far-reaching results of the convention will be the arrangement effected at a special session, under the chairmanship of R. H. Coats, the dominion statistician, and Rev. Father Verreault, chairman of the committee on accounting, whereby it is anticipated that a uniform basis of statistical return and of accounting principles will be accepted in all provinces throughout Canada.

Among the resolutions passed were those calling for legislation which would provide reciprocal recognition by governments of municipalities of the accounts of hospitals for the care of indigents from other provinces; better legislation respecting traffic accidents; a study of building codes and regulations with the idea of eliminating obsolete requirements; endorsing the formation of the cabinet of health to be made up of the provincial ministers of health under the chairmanship of the federal minister of health; expressing desirability that hospitals should be made the center of the health activities of the community and should take leadership in such activities; endorsement of ladies' auxiliaries of hospitals, and many others.

Copies of the various committee studies will be available for distribution in the near future and may be obtained, upon request, from the secretary-treasurer at 184 College Street, Toronto.

Calgary to Be Scene of Alberta's Hospital Meeting

The Annual Convention of the Alberta Hospitals Association will be held in Calgary, November 19 and 20, and will be opened by S. H. Adams, K. C., of the Calgary Hospitals Board. Mayor A. Davison will welcome the delegates and visitors.

"The Control of Surgery" will be the topic of the first morning's meeting, with Dr. A. E. Archer of the Lamont Public Hospital giving the principal address. The afternoon session will be devoted to the discussion of hospital staffs, and Justice Lumey, member of the advisory board of the Holy Cross Hospital, Calgary, will speak on the topic "Hospital Service to the Community." A demonstration in operating room technique and the care of mother and child in a cesarean section will be given at the Calgary General Hospital. Dr. Malcolm T. MacEachern of the American College of Surgeons will deliver the principal address of the evening session on "Cancer—Its Cause and Curability."

Addresses scheduled for the second day's meetings will be given by S. H. Adams on "The Legal Liability of Hospitals," by Dr. R. T. Washburn, University of Alberta Hospital, Edmonton, on "The Edmonton Hospital Prepayment Plan and Its Results to Date," by A. Farmilo, member of the board of the Royal Alexandra Hospital, Edmonton, on "Duties and Viewpoints of a Hospital Trustee," and by Dr. G. Harvey Agnew, secretary of the department of hospital services of the Canadian Medical Association, on "The Hospital Situation in Canada." Dr. A. F. Anderson, Royal Alexandra Hospital, Edmonton, will give a report on "The Canadian Hospital Council."

A demonstration of laundry procedures at the Holy Cross Hospital will be a feature of the final afternoon's meeting.

Hospitals Share in Dementia Praecox Study Fund

A donation of $40,000 by the Supreme Council of the Thirty-Third Degree of the Ancient Accepted Scottish Rite, Northern Masonic Jurisdiction, to aid in the study of dementia praecox was recently allocated by a special committee of the National Committee for Mental Hygiene in New York.

Hospitals, clinics, laboratories, universities, and other scientific centers were selected to share in the grant to be used during the ensuing year. These institutions are in New York, Baltimore, Ann Arbor, Boston, Albany, Providence, Howard, R. I., Chicago, Waverly, Mass., and Philadelphia. The research work to be done by the various institutions will be coordinated in the ten cities.

A report on a survey made preliminary to the work states that dementia praecox constitutes the largest unsolved medical problem confronting modern science. "One-half of all hospital beds in the United States (if not also in the world) are devoted to the care of mentally disordered patients, and of these 35 to 50 per cent are diagnosed 'dementia praecox'," the report states.

Oklahoma Group to Meet

The Oklahoma State Hospital Association will hold its annual meeting at Enid, November 20 and 21, at which time the Fourth District Nurses Association of Oklahoma will also meet. Among the speakers will be Paul Fesler of Wesley Memorial Hospital, Chicago, and Dr. A. R. Hatcher, Wellington, Kans.

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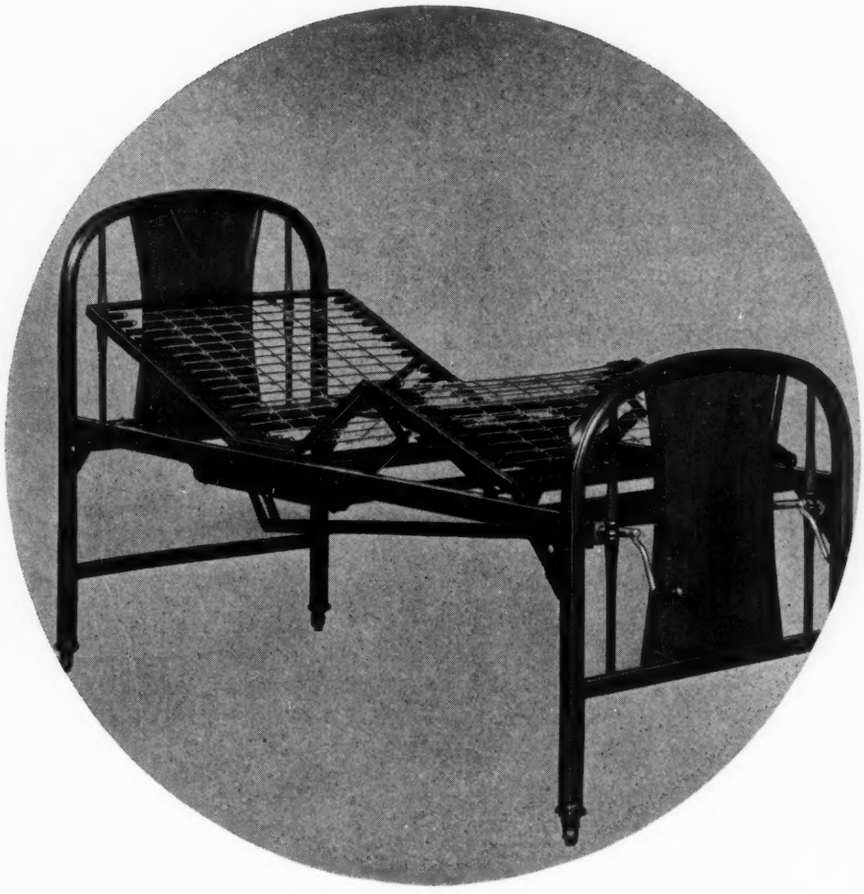

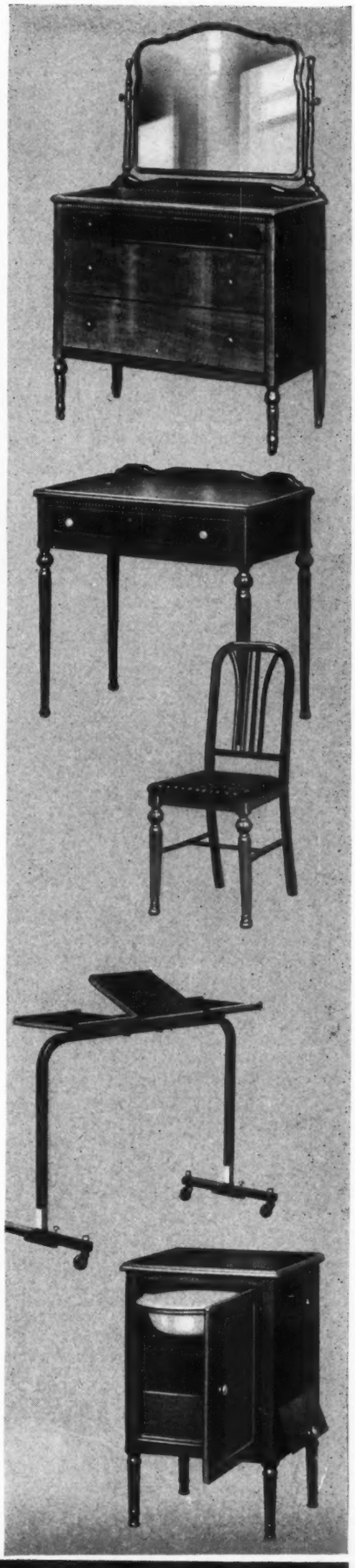

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Ohio Groups Adopt Recommendations for Better Obstetric Practices

Recommendations of the Hospital Obstetric Society of Ohio presented and approved at a recent convention of the Ohio Hospital Association have now become the joint recommendations of the two organizations for Group 1 hospitals. These include hospitals having twenty-four or more bassinets, or more than 300 deliveries per month.

The recommendations, cover, in brief, the following points:

1. There shall be in each hospital a definite organization of the obstetric staff, all members of which are to be elected for ability rather than popularity. The director of obstetrics shall be a F.A.C.S. or diplomate of the Board of Obstetrics and Gynecology.

There shall be definite periods of service. Residents and interns shall not serve in other departments when on obstetric service. The director is to have full jurisdiction over the medical conduct of the department.

A signed pledge shall be required of every physician having the privilege of obstetrics at the hospital, in which he agrees that the care of patients shall be subject to the intervention, supervision and control of the director of obstetrics whenever that is deemed advisable; that he will attend conferences, clinics and meetings of the staff as requested by the director; that he will make all reasonable effort to improve his knowledge of and skill in obstetric practice, and that he will be subject to all rules and regulations made by the hospital for the good of the service.

Routine Technique Recommended

Where major obstetric procedures are indicated, authority must be obtained from the director or his representative. The director and staff shall formulate a routine obstetric technique to which all physicians must subscribe.

2. Records consisting of ante-partum, intra-partum, progress notes, bedside, laboratory and pathologic notes shall be exactly kept and shall be checked, classified and permanently filed. Case records shall be available to the staff for statistical study.

3. Adequate laboratory facilities of all kinds shall be available to the obstetric department. The clinical work shall be discussed regularly.

4. The obstetric department shall provide a single unit of space for patients, containing private rooms, semi-private rooms (two beds), and wards, (private and free) not to exceed four beds. When there is more than one bed, provision for privacy shall be made by screening. Provision for isolation in infected cases shall be mandatory. The nursery shall be soundproof, shall have individual cribs and adequate bathing facilities.

The delivery suite shall be a separate, self-contained unit consisting of a labor or predelivery room, one for each fifteen patient beds, accommodating one person each; and a delivery room, one for each twenty-five beds. Each shall have its complete service room equipment.

The obstetric department shall be under the supervision of a graduate nurse who has preferably had postgraduate training in obstetrics. Nurses shall not be permitted to contact any other service, nor shall nurses from other departments be allowed to serve in the maternity division.

5. A spirit of enthusiasm, idealism and progressiveness shall be stimulated among the personnel.

Florida and Georgia Groups to Meet in Jacksonville

A joint meeting of the Florida and the Georgia hospital associations will be held at Jacksonville, Fla., on November 29 and 30.

The first day's program will be in charge of the Georgia Association, while the Florida group will sponsor the program of the second day. At a public meeting on the first evening, Dr. Bert W. Caldwell, American Hospital Association, has been invited to speak on "The Relation of the Hospital to the Local Community." "The Relation of the Hospital to the Medical Profession" will be discussed by the president of the Southern Medical Association.

Other subjects listed include: "Group Hospitalization" by Dr. L. C. Fischer, and "Nursing Schools and Nursing Service in Small Hospitals" by Alice Stewart, superintendent of nurses, University Hospital, Augusta.

Five-Point Educational Program to Commemorate N. Y. C. Hospitals' Advance in 200 Years

When the two hundredth anniversary of the founding of New York's public hospital system occurs in 1936, the Department of Hospitals intends to have completed a five-point educational program which has been designed and undertaken to place the city's public hospital system in the front rank of the medical centers of the world.

The first step toward the realization of the program as established by Dr. S. S. Goldwater, Commissioner of Hospitals, was made nearly a year ago when a teaching unit comprising 500 medical, surgical, pediatric and obstretic beds at Kings County Hospital was assigned to the Long Island College of Medicine. This constituted a challenge, according to Doctor Goldwater, to the Long Island College to match in Brooklyn the contributions to science, teaching and the better care of patients made at Bellevue Hospital by the three older university medical schools.

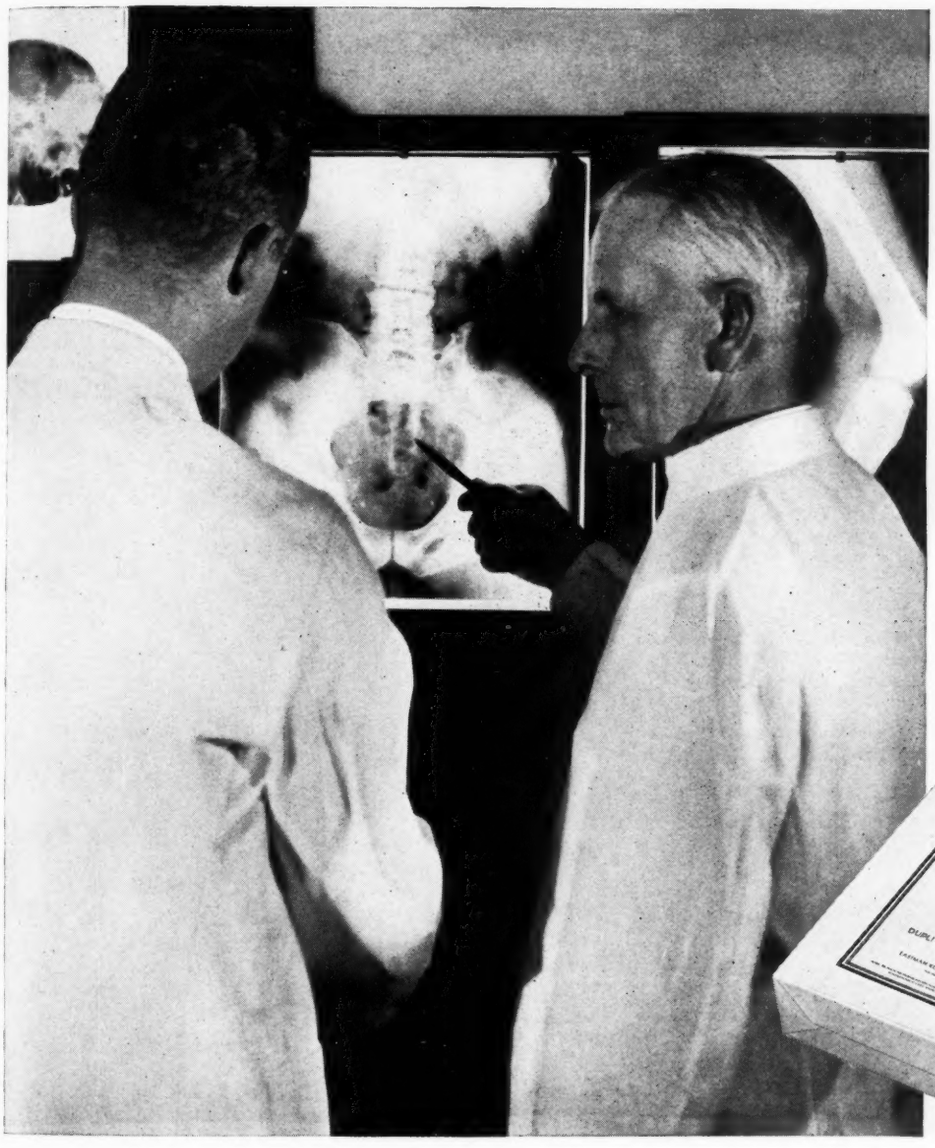
The second step in the realization of the program was the recent transfer of the Metropolitan Hospital from the nonteaching to the teaching hospital group by granting to the New York Homeopathic Medical College the privilege of nominating the visiting staff of the hospital. Other medical schools which already have a similar privilege in other city hospitals are the medical schools of Columbia University, Cornell University, New York University, and the Long Island College of Medicine. Under this system, Doctor Goldwater explains, it is expected to improve the care of patients through the exercise of the teaching function in hospital wards, a method which has been found elsewhere to bring greatly improved results in medical care.

The third step in realizing the complete program will be the creation on Welfare Island of a research and graduate teaching center for chronic diseases. As a nucleus, a ward building is now being renovated and WPA funds have been obtained for the construction of a research laboratory. Mayor La Guardia's 1936 budget carries an item of approximately $20,000 for a research staff to study chronic disease, and a private fund subscribed to by approximately 100 interested individuals and foundations will be used for beginning the work of the new research laboratory.

The fourth step in the program is the encouragement of graduate medical instruction in the various city hospitals. Heretofore, systematic clinical teaching has been confined to undergraduates and has been available in only a few of the hospitals with which medical schools are affiliated.

The final step will be the preparation of an interns' manual which will describe minutely a multitude of clinical procedures with which interns are entrusted. The largest measure of medical economy consistent with sound medical care will be allowed by the department to each medical board, however; technical bedside and laboratory procedures will only be departmentally standardized insofar as such standardization clearly reflects the prevailing consensus.

Three Things You Want from Your X-ray Department:



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Hospital to Reorganize Its Bonded Debt

A reorganization of its bonded debt under section 77B of the amended federal bankruptcy act is being undertaken by the California Hospital, Los Angeles. The hospital has outstanding $720,000 in 7 per cent first mortgage bonds and $750,000 in 7 per cent second mortgage bonds. Interest is in default on the former since April 1, 1934, and on the latter since January 1, 1932.

Under the new plan the holders of the first mortgage bonds will receive an equal amount of new twenty-year bonds dated January 1, 1936, with interest at 3 per cent cumulative. The holders of the second mortgage bonds will exchange them for an equal amount of new second mortgage twenty-five-year bonds with interest at 3 per cent for ten years and then at 4 per cent. The interest on the second bonds, however, is payable only if and as earned and is not cumulative.

The debts of the hospital to trade creditors are not affected by the reorganization and are to be paid in full under a pooling arrangement.

The effect of the reorganization, if approved by two-thirds of the bondholders and by the court, will be to relieve the hospital of interest charges of nearly $60,000 per year.

WPA "Security Wage" Held Too Low

The Illinois Emergency Relief Commission has been requested by the health division of the Chicago Council of Social Agencies to continue to provide medical service to families when they are transferred from relief to WPA projects. In Illinois the relief funds of the state have been used to pay for the hospital care of families on relief if they were hospitalized in certain approved institutions.

In his appeal to the commission, Samuel Goldsmith, chairman of the health division, pointed out that when a man starts to work on a WPA project he and his family are expected to be entirely supported by his "security wage" of about $55 a month. In many instances the family, while on relief, had a budget as high as $100 a month.

Mr. Goldsmith estimated that voluntary hospitals in Cook County are caring for 100,000 relief cases a year and that in three years physicians in these hospitals have provided services worth $2,500,000 to relief clients.

The commission indicated that it would continue to provide medical and hospital care for these families if some way could be found to obtain the necessary funds.

An agreement between the U. S. Federal Employees' Compensation Commission and the joint hospital committee in Washington provides for the care of WPA workers when they are injured while at work. It follows the lines of the agreement with the commission regarding CWA workers except that the per diem rate is raised "not to exceed $4" instead of $3.50 as under the old agreement. This change was made because of the increased cost of hospital supplies and, for certain types of work, increased labor costs.

Radium, Worth $20,000, Donated

A gift of $20,000 worth of radium, approximately one-half a gram, has been bestowed on the tumor clinic of the medical school of Northwestern University, Chicago. The donors are two Chicagoans—Dr. Louis E. Schmidt, surgeon, secretary of the city board of health, and Milton S. Florsheim, manufacturer.

Campaign for Funds Goes Over

The drive for $30,000 recently put on by Harrington Memorial Hospital, Southbridge, Mass., is meeting with great success. According to latest reports from Chas. D. Harrington, the president of the hospital corporation practically $42,000 had been raised.

Hospital Suffers Fire Damage

A fire which started in a closet off the waiting room resulted in minor damages to the Borough Park Maternity Hospital, Brooklyn, N. Y. Several patients were speedily removed to the upper floors while the flames were being routed. Damage was estimated at about $2,500.

Forty-One Enter Nursing School at Russell Sage College

Forty-one students, representing New York State, Vermont, New Jersey, Texas and Florida have been enrolled in the first class of the new Russell Sage College school of nursing, it was announced recently by Adelaide A. Mayo, newly appointed director of the school.

The nurse students who registered as members of the freshman class at the college will take the orientation courses required of all students in the freshman year, with certain changes allowing for more extensive work in the sciences.

Classes during their first year will be held entirely at Russell Sage College. Frequent visits will be made to Albany Hospital for observation and integration.

Lowers Insurance Premiums

The Association of California Hospitals has recently been studying the question of insurance protection for hospitals. The study has resulted in substantial savings in fire insurance premiums. California Hospital, Los Angeles, for example, used to pay $4,400 as a three-year premium on $650,000 of insurance at a 70 per cent valuation. The hospital's insurance has just been rewritten for $1,000,000 on a 100 per cent valuation and the three-year premium for the much larger coverage is only $1,900. The rebate that was due on the former policy which had already been in force over a year was almost sufficient to cover the new premium.

Mexican Government Encourages Hospital Construction Plans in Various States

Extensive hospital building programs are in progress or in contemplation in various places in Mexico, according to a report from Dr. Angel de la Garza Brito, supervisor general, Federal Public Health Service in Mexico.

In Mexico City itself a new hospital has recently been opened by the Mexican Red Cross and a new tuberculosis hospital, being built by the health department will be opened this month or next. A new railroad hospital, Hospital del Ferrocarril, is nearly finished. A tuberculosis hospital, ten years old, is also furnished for railroad employees. In addition, the War Department is preparing plans for a new modern military hospital to replace the present antiquated structure.

In Durango City, state of Durango, the state hospital is being enlarged and modernized. New surgical wards are being constructed and a new maternity center.

The Mexican government is encouraging the various states to build civil hospitals, and it is expected that one modern general hospital will be provided in every city before the six-year plan is completed. While the capital city in each state now has a hospital, most of them are old and lack modern conveniences.

The national health department is planning to build three leper colonies in various parts of the country. The first of these will probably be built at Copilco, D. F., Mexico, a second in the state of Michoacan and a third in the south, probably in Vera Cruz. Each leper colony will have accommodations for approximately one thousand residents in all and will be provided with a 100-bed hospital equipped with modern facilities.

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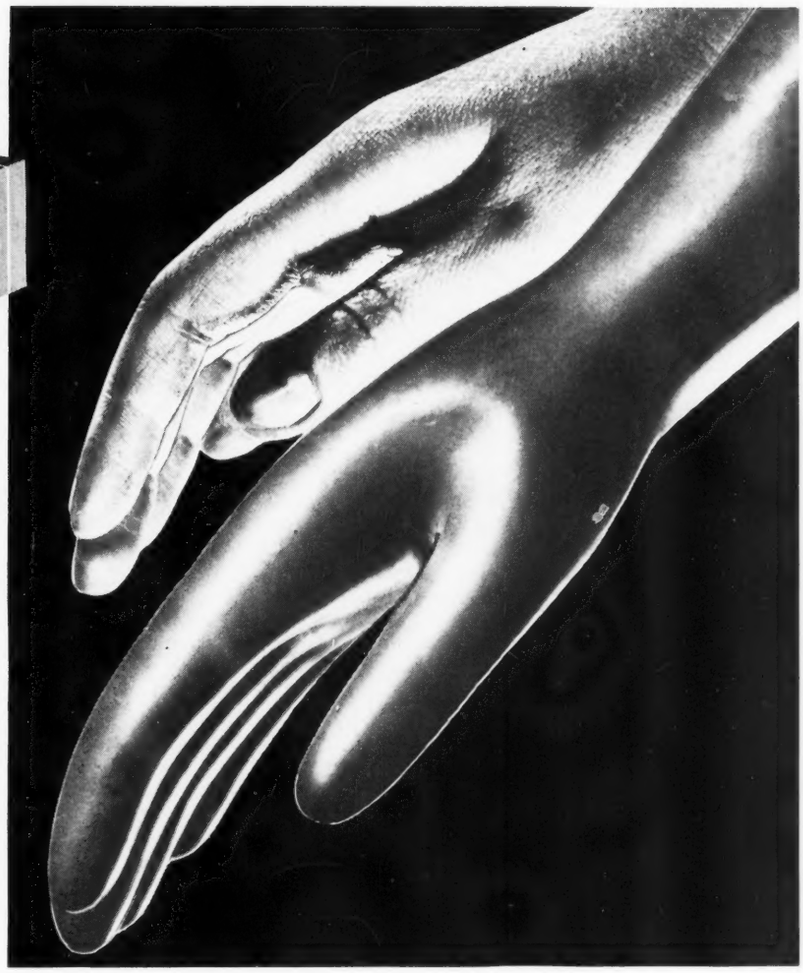

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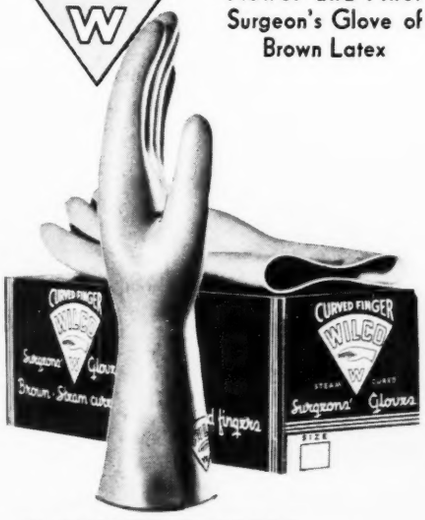

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Abuse of Free O. P. D. Service in Chicago Is Subject of Report

At a recent meeting of the council of the Chicago Medical Society there was presented and adopted a report on the abuse of free medical service in out-patient practice, based on a survey conducted by Dr. William Henry Walsh, hospital consultant, Chicago, for the committee on medical economics, of which Dr. Herman L. Kretschmer is chairman.

The report showed that in the six teaching out-patient departments studied, which handle approximately 60 per cent of the entire free out-patient work, there was abuse of the free service to the extent of 13 per cent. A total of 5,615 consecutive admissions were taken for study.

The purpose of the study was to determine the extent of abuse of free medical service by those able to pay private physicians and to ascertain the standards used in determining the economic eligibility of patients accepted for free care.

The institutions studied were: Central Free Dispensary, Children's Memorial Hospital Dispensary, Mandel Clinic of Michael Reese Hospital, Mercy Hospital Free Dispensary, Northwestern University Medical Clinics, Research and Educational Hospital Dispensary of the University of Illinois. The institutions except one are either directly connected with medical schools or have teaching affiliations.

A family budget used as a measuring rod to determine income eligibility runs from $121.57 a month for a family of five to $45.03 for a working woman living alone. Those within these economic brackets were not considered in the investigation to be able to meet the cost of private medical service except for conditions of a minor nature.

Of the 1,015 families completely investigated it was reported that 66.1 per cent had incomes of less than $1,000 a year; and 90.8 per cent received less than $1,500.

The statement is made that the two institutions with the lowest percentages of abuse are those in which the social service divisions are best administered and staffed.

Among the major recommendations of the report are:

1. That the standards for admission, administration and medical service be improved.

2. That the medical profession take steps to appraise the public of the fact that private medical service is available at a price within the reach of the patient of moderate means.

3. That there be organized a standing committee or council on hospitals and clinics for the purpose of representing the society in all matters concerned with these institutions, and that this council use every endeavor to promote the better coordination between the organized medical profession, the hospitals and clinics and all local agencies concerned with medical service.

"One of the striking points brought out by the home visits," states the report, "was the futility of a considerable amount of professional service rendered in the out-patient departments because of the failure to follow up patients, the inability of many to carry out the instructions given because of impoverished home conditions and the almost complete ignorance of these conditions by the physicians treating the cases in those departments where social service is either deficient or entirely absent. The preventable waste of time and effort of the attending physicians uncovered in this survey due to the factors above mentioned reached proportions demanding the urgent consideration of all concerned."

Alabama Legisture Passes Group Hospitalization Bill

An unusual group hospitalization bill was passed by the Alabama legislature on the last day of its recent session. The bill provides for the incorporation of nonprofit hospital service agencies composed of duly designated representatives of two or more hospitals. The hospitals, however, must first be approved by the trustees of the Alabama Hospital Association and the state board of censors of the Alabama Medical Association. Additional hospitals may be added to any group if they receive the same approval.

The corporation is required to pay a fee of $200 to the state superintendent of insurance for a certificate of authority to do business, which must be renewed annually thereafter. (The law does not specify whether the $200 payment must also be made annually.) Furthermore, the corporation is required to post a bond of $3,000 in government or other acceptable securities before it can do business and thereafter must put up a larger bond as its volume of work increases. In addition to all this, the superintendent of insurance is to be paid 1 per cent of all net premium receipts.

Various rather drastic requirements regarding the group hospitalization contract are made. One specifies a sixty-day waiting period, another requires the benefits to be available to the subscriber when he is away from home, and a third stipulates that the certificate shall state that it does not cover any medical or surgical services but permits free choice of all "reputable" doctors who "are eligible" for membership in county medical societies. All agents of the corporation also must be licensed annually at a cost of $5. Premium rates, benefits and acquisition costs must be approved by the superintendent of insurance.

Within these limitations the state hospital and medical associations are given the right, subject to the approval of the superintendent of insurance, to prescribe rules and regulations for group hospitalization.

At a recent meeting of the Alabama Hospital Association the president, Dr. C. N. Carraway, of Birmingham, who sponsored the group hospitalization bill in the legislature, declared that the amendments that had been inserted at the instigation of the superintendent of insurance had made the bill "unrecognizable."

The Alabama Medical Association recently amended its rules to permit members to practice in hospitals with approved group hospitalization plans and prohibit such practice in hospitals whose plans are not approved. The board of censors of the Alabama Medical Association is legally the state board of health and the state board of medical examiners, a situation that is not duplicated in any other state.

Will Rogers Paid Tribute to California Hospital

The death of Will Rogers recalled to the officials of California Lutheran Hospital, Los Angeles (now known as California Hospital), a letter he wrote them after being a patient in the institution in 1927. A substantial donation to the free bed fund accompanied the letter, which read as follows:

"Sorry not to have answered your letter sooner but I haven't been writing to anybody.

"It's the best hospital I was ever in, they run it like a hotel, only quieter. I stayed there two and one-half weeks, and never got a whiff of Iodoform. The nurses were so congenial I took two of them home with me. My wife liked the place so well she wanted to come and have an operation but she couldn't think what for.

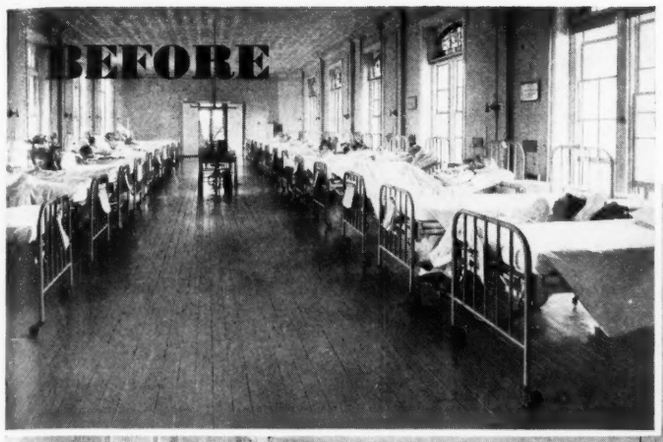
"The Lutheran is not only a religion but a business and they certainly know how to run it.

"Regards and best wishes,

"WILL ROGERS."

Meeting Date Announced

The Tri-Hospital Assembly, comprising the Indiana, Illinois and Wisconsin Hospital Associations, has announced that its next meeting will be held in Chicago on May 6, 7 and 8.



The photographs show a hospital ward before and after remodeling with Sealex Linoleum. Notice how modern and attractive-looking this ward has become since replacing the noisy dirt-catching wood floor with colorful Sealex, resilient and quiet underfoot. Sealex is equally suitable for remodeling, or completing new hospital buildings.

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NEW BUILDING PROJECTS

SAN PEDRO, CALIF. — The site is to be selected and work begun promptly on a new 100-bed, $100,000 hospital for Dr. Forrest E. Dowey. The architect will be G. Garfield Dowey, Altadena. The hospital will include seaplane and motor boat ambulances to augment a regular ambulance service. Intra-harbor ambulance facilities through the use of fast launches is part of the plans.

SAN JOSE, CALIF. — A new emergency room has been added to the San Jose Hospital. It will accommodate five persons. Another change planned is the transformation of the old pharmacy into a cast room where added conveniences will permit doctors to make and place casts on patients.

TAMPA, FLA. — A $90,000 public works grant and a federal loan of $110,000 were made recently by PWA for expansion of Tampa Hospital and the construction of a nurses' home. Under terms of the government allocation 45 per cent is an outright grant and the remainder is in the form of a self-liquidating loan which is to be repaid within twenty-five years.

NAMPA, IDAHO. — A $50,000 addition to Mercy Hospital is being planned. Preliminary plans have been drawn by the architects and the project awaits formal approval of the national headquarters of the Sisters of Mercy. The added space will provide a maternity ward and ten to twelve single and double rooms for patients, an x-ray department, a classroom for nurses and better nurses' quarters.

JERSEY CITY, N. J. — Jersey City has been accorded a loan and grant of $4,545,454 for the construction of a hospital for the development of the Jersey City Medical Center. The present Jersey City Hospital will be enlarged and part of the old structure demolished to make way for the new building. The new building will be twenty-four stories high and will have a water tower. The architect is John T. Rowland, Jr.

RIDGEWOOD, N. J. — The allotment of $432,000 from the PWA for the enlargement of Bergen Pines County Hospital was announced recently.

JAMESTOWN, N. Y. — PWA funds amounting to $80,000 were made available recently for the construction of a new maternity building at Jamestown General Hospital.

PALESTINE, TEX.—The contract has been let for the construction of a new two-story hospital to be built and operated under the direction of several Crockett physicians.

New Community Hospital Opened in Tennessee

The new Holston Valley Community Hospital opened recently at Kingsport, Tenn., is the seventh to have been built under the sponsorship of the Commonwealth Fund of New York as a part of its rural hospital program. Communities in which these hospitals are built are required by the fund to furnish the site for the building, and to assume approximately one-fourth of the cost of building and equipment as well as the operating expenses. The fund then supplies approximately three-fourths of the cost of building and equipment.

The new Kingsport Hospital is a $300,000 project, having fifty-three beds, eight bassinets and a separate home accommodating twenty-five nurses. George W. Eutsler is director of the hospital.

A plan whereby groups of employees are entitled to receive hospital care for a maximum of twenty-one days a year upon the regular payment of seventy-five cents per month has been put into effect. Maternity care after ten months' participation in the plan is included, but conditions provided for under workmen's compensation laws, chronic diseases or conditions known at the time of application to require hospitalization are not included within the scope of the plan.

Building Project Under Way in Richmond

An out-patient clinic and laboratory building, to cost $539,000, is being planned by the hospital division of the Medical College of Virginia at Richmond. Funds for the building have been derived from an anonymous gift of $300,000 and a federal grant of $239,000.

This will be a seven-story structure. The basement and first four floors will be assigned to out-patients and the upper floors to teaching laboratories in pathology bacteriology, biochemistry, public health and preventive medicine. The building will be located in the hospital group and subsequently a new hospital will be constructed adjoining the out-patient clinic.

The clinic and laboratory building is designed in the shape of a T and the hospital will be designed in the shape of a Maltese cross.

West Virginia Hospital Group Meets at Parkersburg

At a recent meeting of the West Virginia State Hospital Association held at Parkersburg, W. Va., Dr. E. F. Heiskell of Morgantown was elected president. Robert Jolly, representing the American Hospital Association, was the guest of honor at the meeting.

A plan was reported as being developed by the association's secretary, James Harris, Jr., which will be presented to the state WPA administrator with the hope that a system may be worked out whereby hospitals will be reimbursed for their care of individuals dependent upon government relief.

A special committee was authorized to work out a plan of procedure in seeking through legislative enactment, a system of state regulation of hospitalization which would result in the raising of hospital standards and administrative efficiency. It was announced that the next annual meeting would be held at White Sulphur Springs.

Lecture Series Begun at Mount Sinai, Philadelphia

As a part of its public health program, Mount Sinai Hospital, Philadelphia, opened in September for its fourth consecutive year a series of free public health lectures developed along the lines of preventive medicine. These lectures will be given monthly at the hospital at 8:30 p.m., continuing until May of next year.

The opening lecture on "What You Should Eat and Why" was given by Dr. Frank E. Leivy who stressed the normal diet for an individual in perfect health, and explained how reducing could be accomplished through proper diet without endangering the health. For use in connection with the talk, the dietary department arranged a special display of reducing diets.

The second lecture on "Heart Disease: Its Prevention and Care" was given by Dr. Joseph Edeiken who answered the questions so often asked as to the symptoms of heart disease, and the conditions which stimulate it. A motion picture entitled "Circulation" accompanied the talk showing the construction and action of the heart and circulatory system.

The lectures will cover such subjects as "The Skin," "Head Colds and Their Complications," "How To Keep Your Children Healthy," "Is Tuberculosis Curable?" "The Cause and Treatment of Asthma and Hay-Fever," "What You Should Know About Diabetes," and "What You Should Know About Cancer."

NAMES IN THE NEWS...

DR. FRED G. CARTER has accepted the superintendency of Christ Hospital, Cincinnati, effective November 15. Doctor Carter is now superintendent of Ancker Hospital, St. Paul, Minn., and is the president of the American College of Hospital Administrators.

WORTH L. HOWARD, assistant director, University Hospitals, Cleveland, has been appointed superintendent of Akron City Hospital, Akron, Ohio, succeeding ARDEN E. HARDGROVE. Mr. Hardgrove is expecting to report for duty as assistant executive secretary of the American Hospital Association December 1. Mr. Howard, who has been in Cleveland for the last four years, was previously assistant director of Montefiore Hospital, Pittsburgh. At one time he served as hospital budget consultant for the Cleveland welfare federation for eight years.

CHARLOTTE JANES GARRISON has resigned as superintendent of Newton Memorial Hospital, Newton, N. J. She has been succeeded by BESSIE ROY who has held the position of nursing supervisor for two years.

HAZEL SANTELMAN, chief dietitian of the Lancaster General Hospital, Lancaster, Pa., for the past five years has resigned to be married. ANNE MUSSER, assistant dietitian, will fill the vacancy and ESTHER MCCLELLEN, Troy, Pa., has been appointed assistant dietitian.

DR. ESMOND R. LONG, director of the laboratory of the Henry Phipps Institute of the University of Pennsylvania, Philadelphia, has been made director of the institute.

WILLIS GRAY has resigned as superintendent of the City Hospital, Cleveland.

H. L. DOBBS, acting superintendent, Kentucky Baptist Hospital, Louisville, Ky., has been named superintendent of the institution.

KATHERINE W. COLLINS has resigned as superintendent of Southside Hospital, Bay Shore, Long Island, N. Y. She will be succeeded by JAMES R. CLARK, assistant superintendent, Jewish Hospital, Brooklyn, N. Y.

MRS. EDNA L. PEW, for thirteen years first assistant superintendent of nurses at the Philadelphia Hospital for Mental Diseases, Byberry, Pa., died recently.

DR. LEO M. CZAJA was chosen in October to be general superintendent of the Chicago Municipal Tuberculosis Sanitarium, Chicago. He will take the place of JOSEPH A. ZIEMBA. Doctor Czaja, who has been chief of staff at St. Mary of Nazareth Hospital, Chicago, served as a captain in the United States medical corps in France.

ROBERTA AINSWORTH, formerly supervisor of pediatric nursing in Robert B. Green Hospital, San Antonio, Texas, is now superintendent of nurses at Sealy Hospital, Santa Anna, Texas.

MARGARET J. BEAMISH, for seventeen years superintendent of Greenwich Municipal Hospital, Greenwich, Conn., and her sister, MRS. E. LILLIAN NICHOLS, assistant superintendent, recently resigned from their positions.

BURTON M. DEARBORN, superintendent of Dearborn Hospital, Medford, Mass., died September 15 of heart disease. He was forty-one years old.

DR. THEODORE WOLLAK has been appointed superintendent of Torrance State Hospital, Torrance, Pa. He has been a member of the medical staff of the hospital for the last four years.

DR. HOSEA W. MCADOO, superintendent of Springfield State Hospital, Sykesville, Mass., for the last three years, has resigned to accept a position at Cambridge, Mass.

HAZEL CHASE, R.N., Bismarck, N. D., has accepted the position of principal of the school of nursing at Huntington Memorial Hospital, Huntington, W. Va., to fill the vacancy left by the resignation of IRENE TOBIN, R.N.

MARCELLA DAVLIN, R.N., has been appointed assistant superintendent of nurses and instructor in practical procedures at Norwalk General Hospital, Norwalk, Conn.

ALMA C. HAUPT, acting director of the National Organization for Public Health Nursing, has resigned to accept the position of director of the nursing bureau of the Metropolitan Insurance Company's welfare division. She will take up her new work January 1, 1936.

HAZEL HUBBS, R.N., Gary, S. D., has accepted the position of director of nursing at Methodist State Hospital, Mitchell, S. D.

ALMA MURPHY, assistant to the superintendent of New England Baptist Hospital, Boston, has been named superintendent of Littleton Hospital, Littleton, N. H. She succeeds MARIANNE HILL who resigned, effective October 10.

AGNES O'ROKE, superintendent, Kosair Crippled Children's Hospital, Louisville, Ky., was married in St. Louis during the week of the A. H. A. convention to Alexander McIntosh of Faichney Instrument Co., Watertown, N. Y.

DR. JOHN G. COPELAND, Albany City Hospital, Albany, N. Y., has resigned to enter the private practice as a dermatologist. EVERETT W. JONES, formerly assistant superintendent of the hospital, has been named director. Mr. Jones attended the recent A. H. A. Institute for Hospital Administrators in Chicago.

EDYTHE M. KILROY is no longer superintendent of Englewood Hospital, Bridgeport, Conn.

MRS. ELIZABETH WOOLSON has become superintendent of St. Luke's Hospital, Milwaukee, succeeding JOAN MUTSCHMANN. Mrs. Woolson was formerly connected with the Veterans Administration Facility at Hines, Ill.

MRS. MARY PARKS, of Uhrichsville, Ohio, has been appointed superintendent of Twin City Hospital, Dennison, Ohio, succeeding CATHERINE DECKER who has been in charge of the institution for three months. MRS. ANNA LONG has been named assistant superintendent and night supervisor.

VIRGINIA MARSHBANKS has resigned as superintendent of Rex Hospital, Raleigh, N. C., and M. E. WINSTON, who formerly held the title of business manager, has been appointed general administrator.

BARBARA KALMESH is the head of the new West Side Hospital at Tracy, Calif., which opened in early October.

MARY SMITH, R.N., has had her contract renewed as superintendent of North Hudson Hospital, Union City, N. J., and has been lauded by the board of governors because of the fact that the hospital is now in its best financial condition in a decade.

MARGARET O'CONNOR, R.N., has assumed the management of the Patchogue Community Hospital, Patchogue, N. Y., under a ten-year lease from Ferdinand Czina, founder of the institution.

ELIZABETH HAWKINS is now superintendent of Susan B. Allen Memorial Hospital, Eldorado, Kans.

SISTER VERONICA is the new superintendent of St. Elizabeth's Hospital, Utica, N. Y., succeeding Sister Antonio, who has been transferred to St. Joseph's Hospital, Syracuse.

DR. JOSEPH W. STAYER has been appointed superintendent of the Smith-Esteb Memorial Tuberculosis Hospital, Richmond, Ind. Doctor Strayer has been for several years resident physician at the Boehne Tuberculosis Hospital, Evansville, Ind.

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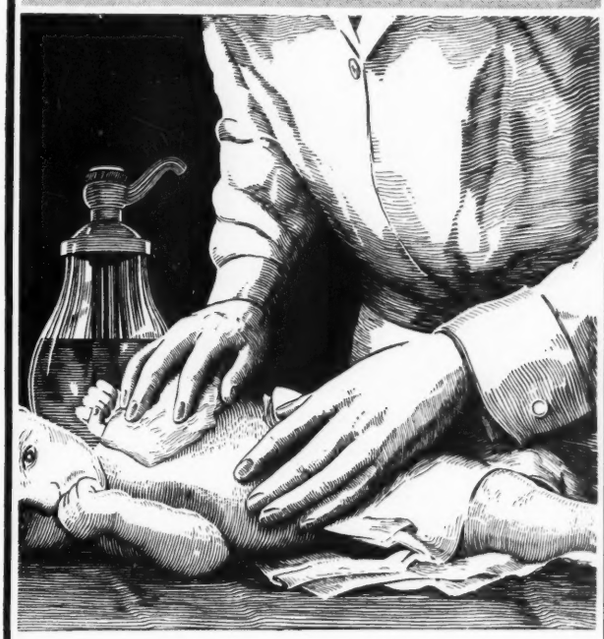

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For Baby-San is made only with first-press olive oil. Unlike other soaps, no inert substances are ever added. Never is there any excess alkali to make the baby uncomfortable.

And bathing requires a minimum of time when you use Baby-San, for it provides a complete bath without the use of oils. When dispensed from the Baby-San Portable Dispenser,* it assures an economical, sanitary and convenient technique—unequalled by any other baby soap.

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READER OPINION • • • •

Hospital Books

Sirs:

Will you please advise the title, price and books that you carry on hospital organization and operation?

J. B. McCULLOUGH,
Office Manager.

Falk Clinic,
Pittsburgh.

The Modern Hospital Publishing Company does not publish or sell any books except The HOSPITAL YEARBOOK and, occasionally, reprints of articles from the magazine.

So far no very extensive literature on hospital administration and operation has yet appeared. Most of the best work has appeared in magazines and reports. A few books, however, are available. These include, in inverse chronological order:

Hospital Organization and Management. Malcolm T. MacEachern, M.D. Physicians' Record Company, Chicago: 1935. $7.50.

Hospital Accounting and Statistics. Council on Community Relations and Administrative Practice, American Hospital Association, Chicago: 1935. $1.

Hospital Administration for Women. Emily MacManus, Matron, Guy's Hospital, London. Faber and Faber, Ltd., London: 1934. 15 shillings.

The Hospital Manual of Operation. Warren P. Morrill, M.D. Lakeside Publishing Company, New York City: 1934. $3.

Accounting and Business Procedure for Hospitals. New York Conference on Hospital Accounting. United Hospital Fund, New York City: 1933. $3.

Hospital Organization and Management (second edition). Capt. J. E. Stone. Faber & Faber, Ltd., London: 1932. £1.

Crisis in Hospital Finance. Michael M. Davis and C. Rufus Rorem. University of Chicago Press, Chicago: 1932. $2.50.

Survey of Nursing Education in Canada. G. M. Weir. University of Toronto Press, Toronto: 1932. $2.

Hospitals and Child Health. White House Conference. Century Company, New York City: 1932. $2.50.

The Small General Hospital (revised edition). W. S. Rankin, H. Hannaford and H. P. Van Arsdale. Duke Endowment, Charlotte, N. C.: 1932.

Private Group Clinics, the Administrative and Economic Aspects of Group Medical Practice. C. Rufus Rorem. University of Chicago Press, Chicago: 1931. 75 cents.

International Studies on the Relation Between the Private and Official Practice of Medicine With Special Reference to the Prevention of Disease; Conducted for the Milbank Memorial Fund. A. Newsholme. Vols. 1-3. Medicine and the State, Vol. 4. Williams and Wilkins, Baltimore: 1931. $4 a volume.

Housekeeping Management in Hotels and Institutions. Crete M. Dahl. Harper & Bros., New York City: 1931. $4.

Medical Administration of Teaching Hospitals. Emmett B. Bay, M.D. University of Chicago Press, Chicago: 1931. $2.

What the Hospital Trustee Should Know. John A. McNamara. Physicians' Record Company, Chicago: 1931. $1.50.

Hospital Economics. Phoebe M. Kandel. Harper & Bros., New York City: 1930. $4.

The Public's Investment in Hospitals. C. R. Rorem. University of Chicago Press, Chicago: 1930. $2.50.

Hospital Administration a Career. M. M. Davis. Rockefeller Foundation, New York City: 1929. No charge.

Nurses, Patients, and Pocket-Books. M. A. Burgess. Committee on Grading Nursing Schools, New York City: 1928. $2.

The Soul of the Hospital. Rev. Edward Garesché. W. B. Saunders Company, Philadelphia: 1928. $1.50.

Clinics, Hospitals and Health Centers. Michael M. Davis. Harper & Bros., New York City: 1927. $5.

American Medicine and the People's Health. Harry H. Moore. D. Appleton & Co., New York City: 1927. $5.

First Steps in Organizing a Hospital. J. J. Weber. The MacMillan Company, New York City: 1924. $3.25.

Hospital Organization and Operation. Frank E. Chapman. The MacMillan Company, New York City: 1924. $4.

Improved Methods in Hospital Management. G. W. Curtis. Hospital Service Exchange, Santa Barbara, Calif.: 1924. $3.25.

Hospital Accounting and Statistics. William V. S. Thorne. E. P. Dutton & Co., New York City: 1918. $1.50.

The Small Community Hospital. John A. Hornsby, M.D. Reprinted from The MODERN HOSPITAL, St. Louis: 1917. $1.

There are several books in foreign languages on hospital administration and, particularly, on planning, reported to be well done. These include:

Svenska Lasavettsbyggnader (Swedish Hospitals). Gustav Birch Lindgren. Broderma Lagerström, Stockholm: 1934. 23½ krona.

Rationeller Krankenhausbau. Herman Distel. W. Kohlhammer, Verlag, Stuttgart: 1932.

Handbücherei Für Das Gesamte Krankenhauswesen. Verlag von Julius Springer. Berlin: 1930. Contained in the series are: I. Krankenhausbau by R. Schachner; II. Fachkrankenhauser by K. Biesalski; III. Sondereinrichtungen Im Krankenhaus by H. Braun; IV. Verwaltung Und Personal by E. von Abendroth; V. Technik Im Krankenhaus by J. Diehl; VI. Ernährung, Diätkuchen, Kostformen by L. Kuttner, and VII. Gesetz Und Recht Im Krankenhaus by Dr. Walter Lustig.

Krankenhauser. Herman Distel. W. Kohlhammer, Verlag, Stuttgart.—Ed.

Alabama Does Not Yield

Sirs:

Alabama, the first state to license and register hospital executives and provide for certain standards, now has an incorporated association of such officials known as the Alabama Association of Hospital Executives. The new organization filed its charter in August and is now getting its first year's program underway.

Mrs. Berta Golightly, superintendent of Garner Hospital, municipal institution at Anniston, is president. Claude Sims, superintendent, Citizens Hospital at Talladega, is vice-president and Emma Ralls, superintendent, Forrest General Hospital, Gadsden, is secretary and treasurer.

The object of the association is "to operate for the welfare of the people so far as can be done by careful management of hospitals; to establish and maintain competent hospital administration; to protect the rights of hospital trustees to select any experienced man or woman qualified to fill the position of superintendent, provided they be registered in the state of Alabama, and to protect public and private funds invested in hospitals from unreasonable demands of other organizations not organized in the state of Alabama."

BERTA GOLIGHTLY,
President.

Alabama Association of Hospital Executives, Inc.
Anniston, Alabama.

In national political conventions, Alabama is the first state to be called. Usually the chairman of the state delegation replies in stentorian tones: "Alabama yields to ———." In this case Alabama does not yield and proposes to set up its own procedure for defining and recognizing competence in hospital administration. The bill for licensing and registration defines a hospital executive as "any person having active charge of the management and general supervision of any hospital in the state."

Any such person who can obtain from the association a certificate of competence may on the payment of $5 obtain from the state treasurer a certificate stating: "The executive of this hospital has met all requirements of the Alabama Association of Hospital Executives and is hereby registered with the State of Alabama as a qualified hospital executive." Provision is made for annual renewal of the certificate with an annual fee of $5.

One of the three officers of the Alabama Association of Hospital Executives, Inc. is superintendent of a hospital fully approved by the American College of Surgeons.—Ed.

"Kicked Around and Robbed"

Sirs:

At a recent meeting of the Tri-State Hospital Association (Virginia, North and South Carolina), a new nomenclature was proposed for the hospital's chief executive. This was unanimously adopted by the convention and the secretaries of each of the constituent state associations were directed to write the chairman of the governing body of each hospital in the three states urging the adoption of the appropriate title. We also voted to ask the American Hospital Association to endorse the idea.

The title "superintendent" has been kicked around and robbed of respect by being too frequently conferred on those whose actual functions are purely supervisory, sometimes menial and ofttimes not in any sense managerial. . . .

As applied to our profession the title "superintendent" does not sufficiently dignify our calling, is inadequate to our responsibilities and is inaccurate in describing our functions. Probably many of the difficulties we encounter may be traced in part to our tendency to self-effacement and unselfishness and to our too commonplace title. We should strive first for competence and then for adequate recognition of that competence.

The recommendations adopted are as follows:

1. That the physician superintendent be known as "administrator and medical director."
2. That the nurse superintendent be known as "administrator and director of nursing," if such is the case.
3. That the nonmedical, nonnursing superintendent be known as "administrator."

The adoption of the appropriate title by each of our hospitals all over the country would be timely now that we have the American College of Hospital Administrators and would be in keeping with the recommendations of that body.

Comment on these suggestions from the readers of The MODERN HOSPITAL would be welcome.

CHARLES H. DABBS,
Administrator.

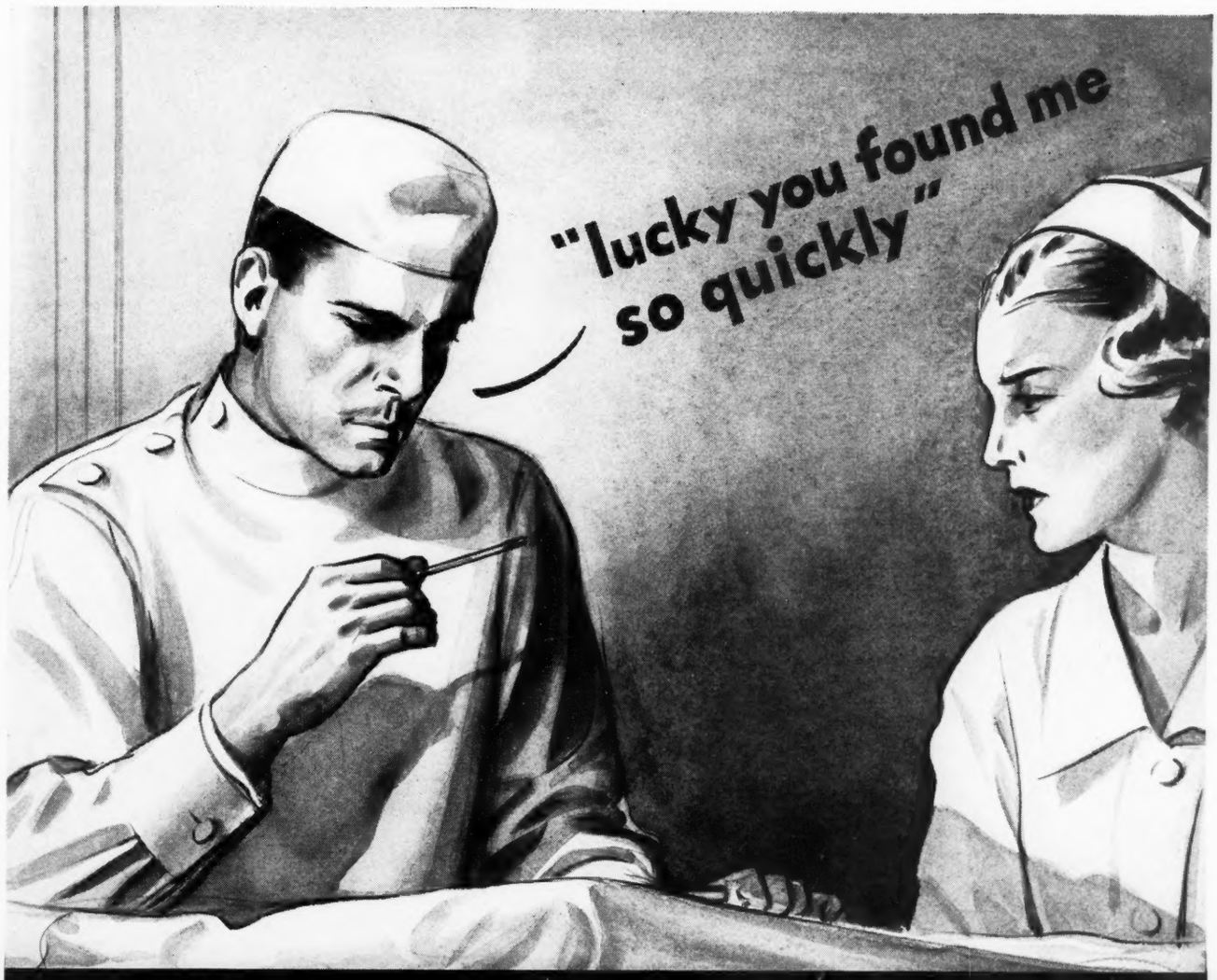
Tuomey Hospital,
Sumter, S. C.

Utah Would Restrict Visitors

At a recent meeting of the Utah State Hospital Association, a resolution was adopted urging all hospitals in the state to adopt a rule prohibiting visitors from operating rooms. It was hoped that this would put an end to a practice which has had an unfavorable effect upon patients.

Retired Sister Honored

The nurses' home of the St. Vincent Charity Hospital, Cleveland, was recently presented by the alumnae of the institution with an oil painting of Sister Marcelline, who served for twenty-five years as superintendent of nursing and retired in 1922.



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LITERATURE *in* ABSTRACT • • •

Conducted by E. M. Bluestone, M.D.

On Vivisection in Hospitals

"On Health's Highway," a brochure released by the New York City Cancer Committee,* depicts, by a series of interesting illustrations, the advances in medicine and surgery since the time of Hippocrates. The booklet, intended for laymen, serves to answer the criticisms leveled against animal experimentation, as well as to point out achievements like the discovery of anesthesia, the advances in bacteriology in the past fifty years, the era of antiseptic surgery, followed closely by the development of aseptic surgery, and their benefits to mankind.

Animal experimentation played an important rôle in these advances and continues to do so, especially in cancer research. Dr. John C. A. Gerster, chairman of the committee, states that cancer research would come to a standstill without the use of experimental animals. The knowledge attained through animal studies has not only been successfully applied for the benefit of human beings but also for the benefit of the animals. Dogs are now inoculated against distemper and treated to prevent the development of rabies. The diseases of animals, bubonic plague, yellow fever, cholera, to which man has been exposed for centuries, have been studied and controlled by animal experimentation and clinical application of the established facts.

It is the purpose of the brochure to emphasize the importance of animal experimentation and to point out the serious impediments to further advances in medicine and surgery if animal experimentation is restricted.

*On Health's Highway, New York City Cancer Committee, 1935. Abstracted by M. Hinenburg, M.D.

Facilities Required in a Sanatorium Laboratory

The sanatorium and the sanatorium laboratory have not grown apace.* There are still many institutions whose sole laboratory personnel consists of a poorly trained expatient, who makes a cursory examination of the sputum for tubercle bacilli.

The modern sanatorium should include, in miniature, facilities for testing and research comparable to those of large general hospitals. These should include facilities for urine analysis, bacteriologic, hematologic, anatomic and histologic, chemical, serologic and experimental studies. The laboratory should also be responsible for the examination of the water and milk supply of the institution, the preparation of tuberculin and kindred types of work.

Failure to utilize the laboratory facilities and the x-ray in diagnosis and management of tuberculosis might be considered a species of criminal negligence. Hospital administrators, particularly public health officials, who send charity patients, paid by their respective communities, to sanatoriums supposedly for modern diagnosis and treatment, should know that they actually receive nothing of the kind in most cases.

The laboratory should have dependable and thorough methods of detecting tubercle bacilli in the sputum, urine and other body fluids. For this purpose, direct smear examination, antiformin concentration, culture methods and guinea pig testing are necessary. Repeatedly negative sputum is significant. The laboratory should have facilities for blood and urine analysis and for the study of gastro-intestinal contents. Although the author does not specify the test, he no doubt considers repeated testing of the sedimentation velocity of the blood a valuable adjunct in the determination of the patient's progress and response to treatment. Serologic examination is an absolute requirement. The laboratory should average one worker for every hundred patients.

*Willis, H. S.: The Place of the Laboratory in the Sanatorium, Am. Rev. Tuber., 32, (Aug.) 1935. Abstracted by Eli H. Rubin, M.D.

How the Depression Has Affected Children's Growth

The author* reviews the conflicting reports concerning the effects of the present economic depression on the growth of children. It is the author's purpose to report a study of population groups in large metropolitan areas and to record the effect of the depression on specific economic classes from 1929 to 1933. In each of the cities of Birmingham, Cleveland, Greenville, S. C., Pittsburgh, Syracuse and Baltimore, 1,000 family case reports were taken. In the same families seriatim measurements were transcribed from the school records of the height and weight of the children. It was thus possible to classify about 5,000 typical working class urban families with 5,400 children.

Three groups were formed (A) those whose income remained $250 or more per capita and who were relatively comfortable, (B) those whose income was less than $250 per capita and who were relatively poor and (C) those who changed from class A to class B because of the depression. Of the 5,400 children, 15 per cent were in class A, 40 per cent in class B and the remainder in class C.

The school records covered an equal number of boys and girls whose ages ranged from six to fourteen years. The data were analyzed on the basis of normal average for the entire group and for a particular age in each economic class. No significant variations were found in the different economic classes for children ten years old or above. Comparing the six to nine year old group it is seen that the continuously comfortable class A families showed children whose weight was 4 per cent greater than the entire group average. The constantly poor class B showed children whose weight was 1 to 2 per cent below the average. The children of the "depression poor" class C showed a weight curve that exhibits a downward trend over the five-year period, starting from a level where the weight is 3 per cent above average and approaching the level of class B 2 per cent below.

While these differences are small, the conclusion seems definite that children six to nine years of age from families of the "depression poor" fail by about 2 per cent to obtain the average weight of the group as a whole.

*Palmer, Carroll E.: Height and Weight of Children of the "Depression Poor," Public Health Reports, U. S. Public Health Service, 50: 1,106, Aug. 16, 1935. Abstracted by Dr. Leonard Tarr.

Overcoming Mental Effects of Illness

In an informal and conversational manner the author* discusses some of the mental reactions of the physically ill. First he describes Kretschmer's constitutional types, stating that the morbid psychologic reactions to somatic illness are usually merely an exaggeration of the mental traits characteristic of each type.

The asthenic or long-thin are physically pale, scrawny, long limbed, with narrow head and face, and narrow chest and abdomen, with a tendency to develop tuberculosis. They are abstemious, dyspeptic, intellectual and self-centered (introverted), dogmatic and fanatical. Mentally they are prone to develop schizophrenic and paranoid symptoms. The pyknic or short-thick are physically compact, thick-set, large bodied, broad through the chest and broader through the abdomen, with a tendency to arteriosclerosis. They are fond of eating and drinking, are extroverted, easy-going and tolerant. They are prone to develop cyclothy-

miac mental symptoms, that is, depressive or manic symptoms.

Aside from the intuitive method of measuring personality which the author considers the most sensitive, an objective study of the patient's behavior and productions, and an analysis of his conscious-unconscious mechanisms are advised.

Disease is just like a quarrel between a particular set of qualities in the human being and adverse forces in the environment. A certain amount of regression to a dependent and child-like state is brought about. The patient's irritability, unreasonableness, apprehensiveness and peculiar behavior are expressions of the regression. These symptoms and more serious symptoms such as delusions, great psychomotor disturbances and depersonalization may be looked upon as attempts of the patient to express his emotions in different dimensions from those ordinarily employed by the healthy.

A psychiatric point of view is then essential for the physician and all others who minister to the ill. Only by understanding the patient's motives can we retain that mutual confidence which helps the patient overcome his fear of disease, and which helps to give him a feeling of healing security in his relationship with his physician. The author emphasizes the hospital's duty to counteract the patient's feeling of homesickness which tends to intensify his morbid psychologic reactions to illness. Occupational therapy and frequent visits to the bedside accomplish much in this direction, and tend to diminish chronicity and other disabling effects of illness.

*Hogan, B. W.: Psychology of the Sick, U. S. Naval Med. Bull. July, 1935. Abstracted by Samuel Atkin, M.D.

Why a Doctor Makes a Good Administrator

We recently reported in these columns a discussion in England on the relative merits of the medical and lay executive in hospitals. The leading editorial in the *Lancet* of August 10 devotes itself to the subject once more and concludes that the doctor is in a more desirable position, from the standpoint of the hospital and the patient, as the chief executive.*

The editor points out the tendency on the part of impatient critics to lay too much stress on small flaws in the machinery of administration and to suggest changes that overlook the objects it is intended to achieve. A medical man is preferable in the executive position if the application of scientific knowledge to the treatment of disease is the desired goal. So far as possible medical officers should, however, be relieved of the details of lay administration, while leaving their responsibility for it unaltered.

Good administration requires that there should be one administrative head of a hospital who, on final analysis, is the one to make decisions and justify them to the governing body. The editor points out that the functions of a hospital are the treatment of the sick, the advancement of medical knowledge, the training of nurses and the teaching of medical students. He argues that all problems of administration are secondary to these objects. What is done and what is bought are more important questions than executive methods. The well-being of the patients and the conditions under which the staff works and learns depend upon the comprehension of the objects of the hospital by its administrative head. Objects like these are best obtained by the employment of medical administrators selected because of their fitness for this kind of work. The burden of lay administration and of work of a clinical character should, of course, be minimized. If the voluntary hospitals are to survive, says the editor, their defects of administration must be corrected and medical administrators would be quick to put their fingers on them and force them upon the notice of the managers.

*The Doctor as Administrator, Lancet, Aug. 10, 1935. Abstracted by E. M. Bluestone, M.D.

Pacemakers of Civilization

"Pacemakers of civilization" — this is how Abraham Flexner describes philanthropists who give out of their possessions, financial and spiritual, that the voluntary institution may live and set the pace for all social endeavor.* Hospitals, universities, libraries, art galleries — they are all in the advance guard of society through the generosity of the voluntary giver. Where would our so-called public institution be if it was not confronted with the challenge of the institutions that are privately conducted through some interested donor desiring to perpetuate these instruments of civilization?

Taking the political and legislative situation in our country as it is, and with an attitude toward prevailing government policies that is entirely uncritical, Flexner asks whether the time may not soon come when taxation, progressively hampering philanthropy, may destroy the usefulness of voluntary institutions by cutting the financial props on which they have been set. He takes the case of the Johns Hopkins Hospital as an epoch-making example of what was accomplished by private initiative at a time when medical education was at a low point. Since his article is based on the address which he delivered as the principal speaker at the fiftieth anniversary celebration of the founding of the Montefiore Hospital for Chronic Diseases in New York, in December, 1934, he has much credit to give to philanthropy for the creation of this unique enterprise in the scientific study of chronic disease.

It is the author's point that present tendencies, particularly with regard to taxation that will dry up the sources of philanthropic supply, if continued, will work untold harm to voluntary agencies and within a short time reduce social, moral and educational standards to the level of many years ago. The author speaks impartially and gives full credit where it is due. It is his obvious purpose to call attention to a threatening situation in the hope that something may yet be done about it.

*Flexner, Abraham: Private Fortunes and the Public Future, Atlantic Month. Aug., 1935. Abstracted by E. M. Bluestone, M.D.

Safety Program Reduces Vehicular Accidents

The author in an effort to encourage others to adopt safety programs publishes his experiences, indicating that for every dollar invested in safety measures four dollars were saved in the form of decreased premiums and other expenses.* The safety program of this concern was undertaken after it was discovered that because of the greater number of vehicular accidents the insurance rates jumped 100 per cent.

The first step taken was to employ a safety engineer. The plant employs 10,000 persons, 4,000 of whom operate vehicles covering sixty-nine cities and towns. The principal causes of accidents were found to be negligence reflected in inattentive driving, carelessness in backing up and speeding. The plan included addresses by the safety engineer and representatives of the insurance company to groups of employees. The economic as well as the humane value of accident prevention was stressed. It was effectively pointed out that no matter how good a driver-salesman might be, the cost of his accidents to the company made him a liability rather than an asset.

A safety committee composed of department heads was formed at each branch. The committee reviewed all accidents and the drivers involved were given hearings. Attractive certificates of safe driving, and bronze, silver or gold buttons were awarded. Quarterly summaries, showing cost of operation per vehicle with and without accidents were issued. Physical health examinations of new employees were instituted. Daily reports of mechanical defects of vehicles were made and drivers instructed to refuse to take out defective automobiles.

During 1934 the number of vehicular accidents as a result of this campaign was reduced by 35 per cent, despite an increase of 10 per cent in commercial vehicular accidents generally

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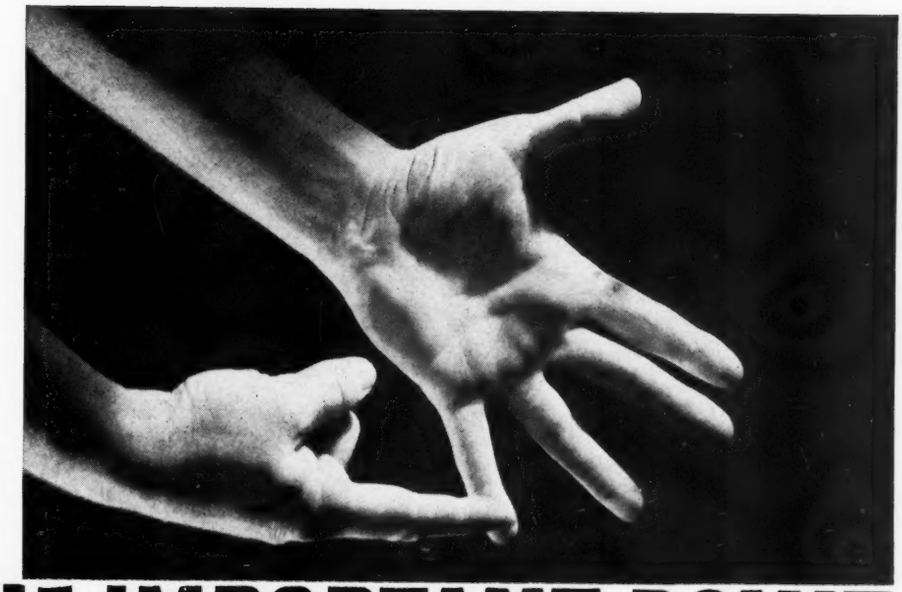

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You may wonder how a machine that costs money to buy can save money when you can polish or scrub floors if necessary without equipment. You might just as logically say that a candle is less costly than electric light. The fact is that FINNELL polishing-scrubbing equipment, properly selected to fit the job, will likely save its cost in the course of a few years. After all, aren't time and labor the principal elements of cost? Thousands of users will testify that FINNELL Equipment and FINNELL floor treatments save both.

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recorded for that year. Thirty-three and one-third per cent of the drivers qualified for a three-year safety button. One branch operating twenty trucks has a three-year record of no accidents of any kind. The cost of repairing vehicles due to accidents was reduced by 40 per cent, and the amount of paid claims for property damage was reduced by 65 per cent. The net saving in lowered premiums and accident costs amounted to more than 40 per cent. The author delicately refrains from mentioning what disposition was made of the careless drivers.

*Brower, A. L.: Investment in Safety Program Yields 300 Per Cent Dividend, Executive Service Bull., Sept., 1935. Abstracted by J. Goodfriend.

Curbing Extravagance

The importance of reviewing statistics on operating costs in hotels day by day is cited as the most effective means of applying corrective measures as they are needed, to produce economies.* While monthly reports give much valuable information they arrive at a time when remedial measures are of no avail.

Reports are submitted by each department head covering the previous day, showing the total number of employees for the day, their positions, hours worked and their rates, so that the day's pay roll expense may be seen at a glance. In addition, other pertinent facts are given such as the number of pieces of linen used, consumption of coal, electricity, water and gas.

The manager thus knows the operating conditions of the previous day, and of the month to date as well, almost before a new day is started. He will have available, for example, in the food department figures on the number of persons served by each waiter, the average amount of fuel required to prepare each 100 meals served, the number of pieces of linen used. This information together with figures on the cost of food consumed enables him to have complete control over the food department. Weekly conferences with the manager and the head of this department have proved successful. Warning signals to the manager are thus established as to when and where immediate attention is needed.

The daily preparation of reports by department heads also has the effect of making them more aware of existing supervision and will tend to curb extravagance. The completed figures are presented to department heads to serve as a stimulus and encourage cooperation.

While the success of a hospital is not measured by the yardstick of profits as it is in hotels, there is much in this article which is applicable to the successful and economic operation of an institution. Daily reports on consumption and expenses have proved valuable.

*Van Horn, F. K.: Daily Control of Operating Costs, Analyst, Sept., 1935. Abstracted by J. Goodfriend.

How to Buy Asparagus

When canned asparagus is to be purchased there are several factors to take into consideration, such as, the kind of asparagus, the size, the grade and finally the price.* There are three general classifications of asparagus which are determined by the time of cutting the product. If the asparagus stalks are cut before they appear above ground they are called white spears or tips. The green or natural tips are those which are exposed to the air only a few hours before cutting, thus causing the tips to be green, while the stalks remain white. Finally, there are the all green spears or tips in which case both the tips and stalks come above the soil before they are cut.

There are eight sizes of asparagus which may be divided into two large groups — those with the long stalks and those with the short stalks. The colossal, mammoth, large and medium are the variations in the diameter of the long stalks, while the mammoth, large, medium and small correspond in diameter to the first group, but have shorter stalks.

The standard grade need not be uniform in size or color but should have a good flavor and be tender. The fancy grade has the additional quality of uniformity. Accompanying this article is an information chart showing the points to consider when purchasing canned asparagus.

*Scott, William A.: Facts About Canned Asparagus, Rest. Management 37:2 (Aug.) 1935. Abstracted by Ruth Marek.

Carrying on Dental Research

In this article the author takes an advanced stand toward the relationship between the medical and dental professions whose activities on behalf of the patient must be integrated to produce the best results.*

The specific points made are:

1. That dentists should attend medical meetings for the purpose of absorbing as much as possible of the medical atmosphere and the medical background of dental practice.

2. That the dental profession should have better representation in the literature of the medical sciences.

3. That greater interest in the selection of properly educated students for admission to schools of dentistry should be shown. The author argues strongly for the elevation of the cultural level of the dental profession.

4. That the organization of dental meetings be such that they will be interesting enough for medical men to attend. This requires a better balance of dental and medical meetings.

5. That a dental department be organized in every hospital where a patient is treated, however small the department may have to be. The author insists on dental representation in the medical board of the hospital.

6. That dentists, physicians, the public and the administration of the hospital should be educated in the importance of dentistry in the treatment of disease.

7. That greater opportunities should be afforded the man with the original mind.

The author reminds us that there are many fields of dental significance still to be explored and thinks the hospital an excellent place for study.

The article concludes with a brief description of the dental organization in the author's hospital, where the governing board has admitted a graduate of the dental house staff to one of the scientific fellowships, thus far available only to medical men.

*Bluestone, E. M.: The Hospital Dentist, Jour. of the Am. Coll. Dentists, Jan., 1935. Reprinted in Dental Outlook, Oct., 1935. Abstracted by David Tanchester, D.D.S.

Better Obstetrics for Farm Women

Farm women can help themselves get good obstetric care by appointing a committee to visit their hospitals.* The committee should inquire whether the hospital is approved by the A. C. S. Pending an inspection the women can, themselves, check the following:

1. The maternity patients' rooms, the delivery room and all other parts of the obstetric unit should occupy an entire floor by themselves, or else be partitioned off with permanent walls.

2. The delivery and operating rooms should be two separate places, not even next to each other.

3. Nurses on duty in the maternity section should do no work elsewhere in the hospital, even if idle.

4. The apparatus, the bed linen, and everything else used in the maternity section should not be used elsewhere in the hospital.

5. Visitors and attendants should be able to reach other parts of the hospital without passing through the obstetric unit.

Farm women should also prevail upon the hospital superintendent or medical staff to arrange that some good obstetrician consult with hospital workers and doctors three or four times a year. Every community of 10,000 people or more should have at least one doctor with some special training in obstetrics.

*Streeter, Carroll P. (with assistance of Drs. A. J. Skeel, Dr. Fred Adair, Dr. James R. McCord and Dr. E. D. Plass): Let Them Live, Farmer's Wife, Nov., 1935, p. 9. Abstracted by Alden B. Mills.

BOOKS ON REVIEW

HOSPITAL ORGANIZATION AND MANAGEMENT. *By Malcolm T. MacEachern, M.D. Chicago: Physicians' Record Co.* 1935. *Pp.* 968. *Illustrated.* $7.50.

This work is profusely illustrated with useful forms employed throughout the hospital field in the conduct of institutional work. Particularly are the drawings introducing each chapter and visually describing what is to come an interesting and attractive innovation in standard textbook publications.

One not acquainted with the author of this splendid book will quickly infer from perusing his long list of honors, memberships and scientific societies and the positions of leadership which he has held, as set forth on pages 943 and 944, that he is amply qualified to express an authoritative opinion on the subject of hospital administration. Those in the field who for a decade or more have had an opportunity of coming in contact with the author's personality must welcome the addition of this monumental work to hospital literature. The chapters on the history of hospitals are informative and very much worth while. The methods of promoting and building the new hospital, as set forth in chapter three, should be of much assistance to a community contemplating the addition of such facilities to its social set-up.

The contribution which must strike the seasoned hospital administrator as most important is the compilation of a great mass of practical data useful in everyday hospital work. This essential quality of practicability properly flavored with theory should serve hospitals of all sizes and types.

Favorable comment should be made upon the organization charts employed by the author and upon the clear elucidation of the opinion of leaders in the field as to the proper integration of the dietetic, social service, nursing, business and other major hospital divisions into the whole organization. Should one be in doubt as to the duties and authority of the dietitian, for example, he will find ample answer to this question.

Standing orders are described in fifty-two pages of the text and are of such completeness and clarity that any hospital not having adopted this system will be greatly assisted in so doing. As would be expected from the author's many years of interest in medical records and in the business conduct of the hospital, these important subjects have been given ample consideration. Staff relationships, the organization of the medical visiting group and ethical problems involving staff functioning are all splendidly handled.

Following the description of the organization and functioning of each specialty department are to be found elaborate check lists of supplies and equipment necessary to its conduct. The reviewer has always felt that such lists are of inestimable value to the hospital executive who is endeavoring to learn of the necessities for the proper conduct of a scientific division.

It is impossible in limited space to enumerate the many virtues of this volume. Suffice it to say that for years to come Doctor MacEachern's contribution to the hospital literature will no doubt be considered as a standard work to be found on the superintendent's desk, reference to which will be discovered to be a daily necessity.

The book has an introductory note by six outstanding hospital administrators, and a carefully prepared index of 52 pages. — JOSEPH C. DOANE, M.D.

NOTES *for* BUYERS • •

The Eyes Have It

There is an important eye operation this morning. The surgeon wants an already threaded suture — he heartily dislikes that tedious and difficult threading of small-eyed needles in the operating room. Davis & Geck, Inc., 217 Duffield St., Brooklyn, N. Y., respond. They offer a new line of sutures specially designed to meet the exacting conditions in eye surgery. Swaged into the hollow end of special "Atraumatic" needles, the sutures not only eliminate needle threading but, what is perhaps more important, they are said to produce a minimum of tissue trauma. An excellent D&G booklet describes them fully.

Mind Over Money

As conscientious radiologist, you acknowledge that you have x-ray tubes which should be replaced. But the purchasing executive, while he eagerly buys inner tubes for hospital ambulance tires or for his own trusty wagon, hesitates to O. K. that x-ray tube replacement.

Along comes a booklet from General Electric X-Ray Corp., Chicago, heralding "Here's Real Tube Economy." Two Coolidge tubes in one — at the former price of one — and a liberal allowance on any of your old tubes or parts.

Why is it two tubes in one? Let's give you the thumbnail description offered in the folder: "With two focal spots in the same tube, either available for instant use by the simple flick of a switch, the operator is equipped for the finest bone work with the smaller focal spot, as well as for work on the heavier parts of the body requiring the large focal spot of greater energy capacity." They say, too, that it is a more powerful, faster cooling tube.

Within the Boot of a Vasculator

Sugar the pill, make them comfortable, call it what you will—the patient pictured in the folder on the new Collins Vasculator seems thoroughly at ease. In semi-reclining position, his entire leg is within the boot of the vasculator, that machine for administering alternate suction and pressure for the treatment of advanced peripheral vascular disease.

This Vasculator consists of two principal parts (1) the power plant and (2) the boot or chamber for the extremity. It follows the Landis curve of alternate suction and pressure which is the application of from 80 to 120 mm. of mercury suction, followed by a fairly rapid change to pressure of from 60 to 80 mm. of mercury. Suction is maintained for 25 seconds and pressure for 5 seconds.

For the large hospital desiring to treat more than two patients at one time, the multiple Vasculator, also made by Warren E. Collins, Inc. (555 Huntington Avenue, Boston), will operate from one to six boots simultaneously from a single power plant.

Quadruplets—All Boys

Canada and England seem to surpass us in this matter of many babies all at once. Consider a news item from London: "Quadruplets, all of them boys, were born at the Royal Free Hospital tonight and all are surviving. . . . The mother is Mrs. Victoria Harmsworth, wife of a metal polisher." Victorious she may well be, if she succeeds in rearing the four!

But the United States, aided by Hospital Appliances, Inc., does its best to keep up. The Pittsfield, Mass., company has just introduced a new obstetric bed invented by Dr. Malcolm T. MacEachern (and appearing the same day, by the way, as his nearly-one-thousand-page book "Hospital Organization and Management," published by Physicians' Record Co., Chicago).

But write for a booklet. It explains that the bed, unlike the conventional split table, is constructed on a one-piece frame, ensuring rigidity; that it's quickly elevated to the shock position; is readily raised or lowered to suit the height of the stretcher as well as the height of the physician, and that the newly designed stirrups and foot rest mean comfort for the patient, ease and rapidity of adjustment.

It Pays to Mechanize

There are in America, they say, more mechanical servants than they have in China. Comes another, and up in the diet kitchen they're holding open house to celebrate. For the new General Electric Kitchen Waste Unit is essentially diet kitchen equipment (it's also welcomed in the kitchenette over at the nurses' home). This device, powered by a small electric motor that is said to operate for less than one-half cent a day, reduces garbage (including bones) to a thin pulp and flushes it down stream, via the drain and the sewer. And odors can't help themselves, they go right along!

Let's Have Another Cup of Coffee

Fortune magazine tells why the English are such tea drinkers, the Americans such coffee lovers: "English water makes excellent tea, though it makes inferior coffee. And much American water, while it makes good coffee, makes inferior tea."

Enters the new "Toastmaster, the latest in automatic coffee making," and the predilection for coffee obtains an even stronger hold on Americans. No, this beautiful stainless steel and chromium finished coffee maker does not achieve crisp toast — it produces the kind of coffee you want. Clear, no sediment; delicious, not bitter. "One urn, one valve, one burner," further explains McGraw Electric Co., Waters-Genter Division, Minneapolis, "and coffee making by the improved French drip method."

Paging New Literature!

Chart-Wise and Otherwise — Having difficulty in gathering material for that Foods and Nutrition class? Ralston Purina Co., Checkerboard Square, St. Louis, offers to help — with charts for the cereal lessons. Available is a large wall or poster-type chart and a smaller sheet for loose leaf note books. Ably it analyzes the nutriment in a grain of wheat. Cross-sectioned, this helpless grain of wheat nakedly exposes its endosperm, bran and embryo, with definitions of each. In writing for these charts, you might keep in mind a couple of colorful booklets on the Ralston Wheat Cereal and the Ry-Krisp Whole Rye Wafers.

Little Brown Jug — With fall and football, one reflects it's time for two great state universities to battle for possession of *the* little brown jug. If Michigan wins, she appropriates the jug. If Minnesota defeats Michigan — but why should they struggle so hard for that one jug when one can buy little brown jugs by the dozen, and attractive ones too, from the Hall China Co., East Liverpool, Ohio? And the little jug is only one feature of this company's new catalogue. Who can resist that individual

pudding pan, that New England bean pot (note that it has a handle, while the Boston bean pot has none), or that New York casserole? And does not this fireproof cooking china keep food hot, fresh, pure flavored? Granted. It also comes in your preferred color and may be decorated to suit your requirements.

Dietitians, Harken to Health Recipes for Tiny Tots—It's almost a child's garden of vegetables, this part of "Electric Cookery" that's devoted to recipes and menus for little children. Dressed up in a bright gingham-pattern cover, the booklet is from Edison General Electric Appliance Co., Inc., Chicago, and is prepared by the company's home economics department. A child's vegetable luncheon is outlined, as well as a brief list of typical menus for children. This company, by the way, also issues a large catalogue of electrical cooking and baking equipment (from coffee urns to ranges). A special feature article is "Operating Costs," treating in part the matter of fuel and its cost in hospitals.

She's Off Duty — In a New Fall Cape — The first step to professional attitude is professional appearance, suggests Standard Apparel Co., 5604 Cedar Avenue, Cleveland. That Standard-ized cape helps to keep a student nurse "profession minded" and besides, a luxurious, attractive new cape warms her up to her new environment. She and the graduate nurse, too, like its tailoring to individual measure; its full lining; the inside pocket, and those embroidered initials (the hospital's and the nurse's).

A Suture Serial in Four Parts — This series on Curity sutures and ligatures would seem to belong in the category of "I must read" booklets. For these little white books prepared by the Lewis Manufacturing Co., Division of the Kendall Co., Walpole, Mass., contain excellent information for the medical and surgical profession. Titled "Gastro-Intestinal Sutures," "The Advance in Absorption Control," "Plain and Chromic Catgut," and "Dermal and Tension Sutures," they cover such subjects as the technique of manufacture and the specialized uses for sutures and ligatures. Another booklet, copyright 1934, and belonging in this quintet is one titled "Sterilization and Bacteriological Control." It discusses catgut sterilization.

Just a Little Hot—a Little Cold—Anyone who has ever had his nice warm shower suddenly turn freezing cold or —what's worse—boiling hot, should be glad to hear that such incidents can be prevented by the installation of an automatic mixing valve. Perusing Bulletin No. 258 which has just been received from the Powers Regulator Co., 2720 Greenview Avenue, Chicago, we learn that the secret of safe shower mixing lies in the pressure equalizing valve which controls and equalizes the pressures of hot and cold water before they enter the mixing chamber. Several types of regulators suitable for showers and hydrotherapeutic equipment are described in detail with illustrations and diagrams.

Nurses Need Not Be Nameless — Do they call to her "Oh, Nurse!" Or do they pay her the compliment of using her name? She is Miss Martin to patient and doctor if her name is attached to her sleeve, to the pocket of her uniform or perchance, to her cap. Cash's woven names in a larger size and woven on half inch tape are now available and the result is that nurses may escape that unflattering namelessness. Also, suggests J. & J. Cash, Inc., South Norwalk, Conn., certain titles may be indicated in this way as "Supt. of Nurses" or "Dietitian." Many of us were brought up through boarding school on "cashwoven" names — but did you know that these can now be attached to clothing by No-So Cement?